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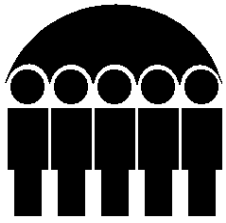
Employees' Manual
Title 14
Chapter C

MEDICAL SYSTEMS



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CHAPTER OVERVIEW

The purpose of this chapter is to provide information regarding many of the medical-related systems, informational screens, and WIFS messages. This chapter covers the following topics.

- HREF = Referral system, which transmits referrals from the local office IM worker to the HIPP Unit or the ***hawk-i*** program.
- Managed heath care systems. This section provides a brief explanation of:
  - The different managed health care options.
  - How to determine which program a client is enrolled in.
  - When a notice is generated to a client enrolled in a managed health care plan.
- MediPASS provider on-line display (PROV), explaining how to view eligible MediPASS providers.
- MEPD billing screens, which display premium amounts and payments for clients in the Medicaid for employed people with disabilities coverage group.
- MIPS billing screens, which display premium amounts and payments for clients in the IowaCare coverage group.
- PRSM = Presumptive Medicaid Eligibility, which records eligibility decisions made by qualified providers for pregnant women and women in the breast and cervical cancer treatment group.
- SSBI = Buy-in System, which records the Medicaid payment of Medicare Part A and Part B premiums for eligible recipients.
- SSNI = Medicaid Eligibility File, which displays Medicaid eligibility information used to process Medicaid claims.
- WIFS (warnings, informational, fatal, and summary messages). This section provides information regarding the WIFS system and the WIFS E-mail messages an income maintenance worker could receive from a medical system.

Other Resources Available

There are other systems available that may provide you with information regarding a client's medical coverage.

- The Income Eligibility Verification System (IEVS) is accessed through the ABC system LINK MENU. IEVS allows access to the Beneficiary and Earnings Data Exchange (BENDEX) screens, which provide Medicare coverage information. See 14-G, *EXCHANGE OF DATA WITH OTHER AGENCIES*.
- The Individualized Services Information System (ISIS) provides Medicaid facility and home- and community-based waiver information. This system can be accessed through the Department's DHS Intranet IM web page: http://dhsintranet/field/asp/im.asp. See 14-M, *ISIS USER GUIDE*.
- The Medicaid Management Information System's Medically Needy subsystem provides spenddown information for Medically Needy cases. It is accessed through the CICS System. See 14-I, *MMIS MEDICALLY NEEDY SUBSYSTEM*.
- MEPD Premium Change screen can be accessed from the ABC SYSTEM MENU (TD00). For more information, see 14-B(4), MEPC = MEPD Premium Change.
- MIPC Premium Change screen can be accessed from the ABC SYSTEM MENU (TD00). For more information, see 14-B(4), MIPC = IowaCare Premium Change.

HREF = REFERRAL SYSTEM

The HREF (Iowa Referral Systems Menu) is used to allow staff to access:

- HIPP referral screens
- ***hawk-i*** referral screens

The HREF screen can be accessed by:

- Signing on to CICS. Clear the screen, type HREF, and press the ENTER key. Type the nine-digit ABC case number in the CASE field, type an "X" in the OPTION, and press ENTER; or
- From the ABC case's TD03 screen. Press PF6=REF MENU and the system displays the HREF Menu. The case number and the name of the person from the TD03 screen are automatically displayed in the designated fields. Type an "X" in the referral option and press ENTER.

```
HREF                              IOWA REFERRAL SYSTEMS MENU
CASE:  XXXXXX XX X X      LAST:                          FIRST:
SELECT ONE OF THE FOLLOWING:
 - HEALTH INSURANCE PREMIUM PAYMENT REFERRAL (HIPP)
- HAWK-I REFERRAL ON CANCELLED CASE OR CHILD
- HAWK-I REFERRAL ON DENIED APPLICATION OR CHILD
- HAWK-I REFERRAL ON A VOLUNTARILY EXCLUDED CHILD
  -      CHILD WAS EXCLUDED DUE TO INCOME
  -      CHILD WAS EXCLUDED DUE TO RESOURCES
- HAWK-I VIEW REFERRAL HISTORY
ENTER "X" ON THE APPROPRIATE OPTION AND PRESS ENTER TO BEGIN PROCESSING
PF01=STOP   PF04=TD03
```

To leave the Iowa HREF = Iowa Referral Systems Menu and the ABC system, press PF01=STOP. To leave the HREF = Iowa Referral Systems Menu and return to the TD03 screen from which the referral process began, press PF04=TD03.

Note: If you need to make a HIPP referral and an automated ***hawk-i*** referral on a voluntarily excluded child, a denied child, or a canceled child on the same day, for ease of navigation, complete the ***hawk-i*** referral first, then press PF03 = MENU. This returns you to the Referral Menu, and you can then select the referral type "Health Insurance Premium Payment Referral (HIPP)."

HIPP Referral Screens

The HIPP Referral Screens are used to:

- View the current policyholder referral lists that may or may not exist for the employed adult by their state ID number.
- System-generate new HIPP referrals for adults that are employed.
- Refer all ending employment to the HIPP referral system. This ensures that a HIPP referral is made whether or not there is an active HIPP case.
- System-generate reports of ending employment.

HIRFLST = HIPP Policyholder Referral List Screen

HIRFLST, the policyholder referral list screen, can be accessed only from the HREF = Iowa Referral Systems Menu. Type an “X” in the column next to the “HEALTH INSURANCE PREMIUM PAYMENT REFERRAL (HIPP)” row and press the ENTER key. Referrals created are displayed on this screen with the most recent referral appearing at the top of the list.

```
 HIRFLST                HEALTH INSURANCE PREMIUM PAYMENT
                            POLICYHOLDER REFERRAL LIST

 STATE ID:  XXXXXXXX        ABC CASE#: XXXXXX  XX  X  X        SSN: XXX  XX  XXXX
 LNAME: XXXXXXXXXX          FNAME:  XXXXXXXXX                COUNTY:  XX
                                                 EMPLOYMENT   REF    WORKER
S  REF DATE    EMPLOYER                          END DATE     SRC    CNTY/ID
---------------------------------------------------------------------------------
_  MM DD CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM DD CCYY    X     XX XXXX
_  MM DD CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM DD CCYY    X     XX XXXX
_  MM DD CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM DD CCYY    X     XX XXXX
_  MM DD CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM DD CCYY    X     XX XXXX
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_  MM DD CCYY  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM DD CCYY    X     XX XXXX
---------------------------------------------------------------------------------
 PF01=        PF02=ADD REF     PF03=      PF04=        PF05=       PF06=
 PF07=UP      PF08=DOWN        PF09=      PF10=        PF11=       PF12=TD03
```

The system carries over six fields of data from the ABC system, based on the information associated to the TD03 that you were using when you moved to the HREF system. Those six fields are: (STATE ID:, ABC CASE#:, SSN:, LNAME: (last name), FNAME: (first name), and COUNTY: (worker county).

See HIPP Referral Case Actions for instructions on adding, changing, deleting and viewing referrals.

The function keys available on the HIRFLST screen are:

PF02 = ADD REF	Allows adding a referral to the HIRF system. Once the HIPP system updates in nightly batch processing, the only changes that can be made on an existing referral using the PF04 = UPDATE key are to: ♦ Add the ending employment date, and ♦ Add the code to indicate COBRA AVAIL information.
PF07 = UP	Allows moving backward to previous policyholder referral list screens.
PF08 = DOWN	Allows moving forward to additional policyholder referral list screens.
PF12 = TD03	Returns you back to the TD03 screen where you initiated your referral.

HIRFDET = HIPP Policyholder Referral Information Screen

```
HIRFDET                    HEALTH INSURANCE PREMIUM PAYMENT
                           POLICYHOLDER REFERRAL INFORMATION

REF DATE:  MM DD CCYY

STATE ID:  XXXXXXXX          ABC CASE#: XXXXXX  XX  X  X          SSN: XXX  XX  XXXX

LNAME:                       FNAME:                          COUNTY:  XX

EMPLOYER:  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          REF SOURCE:  X

DOES THIS STATE ID BELONG TO THE POLICYHOLDER:   X

PH LNAME: XXXXXXXXXXXXX     FNAME: XXXXXXXXX      MI: X

PREGNANT PERSON IN THE HOUSEHOLD:  00 00 0000          DUE DATE:  00 00 0000

EMPLOYMENT END DATE:  MM DD CCYY                       COBRA AVAIL: X
COMMENTS:


ADD:  08 25 2004  77CMD2                  UPD:  00 00 0000

PF01=      PF02=ADD   PF03=          PF04=UPDATE   PF05=REFRESH   PF06=LIST
PF07=      PF08=      PF09=DELETE    PF10=         PF11=          PF12=TD03
```

The HIRFDET screen is the policyholder referral screen. This is the screen you will use to:

- Review an existing referral,
- Change the employment end date and cobra avail fields or to
- Create a new referral.

Information from the ABC system is automatically displayed at the top of the screen for the following fields: REF DATE:, STATE ID:, ABC CASE#:, SSN:, LNAME:, FNAME:, and COUNTY.

This screen also includes the fields listed below. These fields will either display information entered on previous referrals or require worker entry of the information to change an existing referral or make a new referral. (See HIPP Referral Case Actions.)

- **EMPLOYER:** Employer's name.
- **REF SOURCE:** The code for the worker that made the referral. Source codes are:

  F Field referral
  H ***hawk-i*** referral

  Note: The HIRF system tracks ***hawk-i*** referrals separately.
- **DOES THIS STATE ID BELONG TO THE POLICYHOLDER:** The code indicates whether the state identification number listed belongs to the policyholder. Acceptable codes are "Y" (yes) or "N" (no).
- **PREGNANT PERSON IN THE HOUSEHOLD:** The code indicates whether there is a pregnant woman in the household.
- **DUE DATE:** The projected month, day, and year of the birth, if known, when there is a pregnant woman in the household.
- **EMPLOYMENT END DATE:** The date employment ended.
- **COBRA AVAIL:** The code indicates whether COBRA benefits are available to the person.

You may continue to change this screen using the PF04=UPDATE key or delete the referral using the PF09=DELETE key until HIPP processes the information in the nightly batch processing.

The function keys available on the HIRFDET screen are:

PF02 = ADD REF	Used to add a new referral
PF04 = UPDATE	Used to change an existing referral before the nightly batch processing or to update the EMPLOYMENT END DATE and COBRA AVAIL fields.
PF05 = REFRESH	Gives a "blank" screen so another referral can be added for the current state identification number. The "blank" screen will still have the information you brought over from the TD03 screen but you will have to enter the employer information.
PF06 = LIST	Returns you to the HIRFLST screen for the displayed state identification number.
PF09 = DELETE	Allows deletion of a referral created earlier in the day, before the nightly batch processing.
PF12 = TD03	Returns you to the TD03 screen for the displayed state identification number.

HIPP Referral Case Actions

The following sections explain the procedures for:

- Adding a HIPP referral
- Changing or updating an existing HIPP referral
- Deleting a HIPP referral on the same day you made it
- Viewing existing HIPP referrals

Adding a HIPP Referral

A HIPP referral is applicable when an adult has earned income (excluding self-employment). See 8-M, HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (HIPP). Use the following step/action chart to add a HIPP referral.

Step	Action
1	Access the case on ABC.
2	Go to the TD03 screen of the person with employment. **Note:** The HIPP referral should be made from the TD03 screen of the policyholder. If the policyholder has no state identification number, there will not be a TD03 screen. In this situation, make the referral from the TD03 screen of any Medicaid-eligible person on the case.
3	On the HREF menu screen, select HIPP referral by entering an "X." Press ENTER.
4	On the HIRFLST screen, check if a referral for this employer has already been completed. If the referral is already on the list, press PF12=TD03 to return to the TD03 screen in ABC. If the referral is not on the list, press PF02=ADD REF and go to next step.
5	On the HIRFDET screen, make entries in the following fields: ♦ EMPLOYER: Enter employer's name. ♦ REF SOURCE: The system populates this field by default with an "F" for field. If a ***hawk-i*** worker is making the referral, enter an "H." ♦ DOES THIS STATE ID BELONG TO THE POLICYHOLDER: Enter a "Y" (yes) or "N" (no). If you enter "Y," you may enter additional comments in the COMMENTS field or press PF02 to add the referral. If you enter "N," you will be taken to the policyholder (PH) name fields and required to enter the last name (LNAME) and the first name (FNAME) of the actual policyholder. You may enter comments in the COMMENTS field. ♦ PH LNAME: Enter last name of policyholder. ♦ FNAME: Enter first name of policyholder. ♦ MI: Enter first initial of middle name of policyholder.

	♦ PREGNANT PERSON IN THE HOUSEHOLD: Enter a "Y" if there is a pregnant person in the household. **Note:** Leaving this field blank causes the cursor to skip over the DUE DATE: field. If the due date is unknown, no entry is required. ♦ DUE DATE: Enter the due date, if known, in MM/DD/YYYY format. **Note:** This field will not allow an entry if an "N" was entered in the PREGNANT PERSON IN THE HOUSEHOLD: field. ♦ COMMENTS: Enter any additional comments. This field is optional. Press PF02=ADD REF. Check to see if a message is displayed at the bottom of the screen indicating that a referral has been added. If you enter something incorrectly, you will get an on-line error message telling you what to enter.
6	If no other referrals are necessary, go to Step 7. If you have another referral to add for the same state identification number, press PF05=REFRESH. A new blank screen will appear. See Step 5 to complete and add the referral.
7	To exit the HIRFDET screen, press: ♦ PF06=LIST to return to the list screen to view the added referral, or ♦ PF12=TD03 to return to the TD03 screen in ABC.

Changing or Updating an Existing HIPP Referral

Use the following step/action chart to make changes on an existing HIPP referral before the nightly batch processing or to update ending employment and COBRA information.

Step	Action
1	Access the case on ABC.
2	Go to the TD03 screen of the person whose HIPP referral needs to changed. Press PF06=LIST.
3	On the HREF menu screen, select HIPP referral by entering an "X." Press ENTER.
4	On the HIRFLST screen, select the referral that needs to be changed by entering an "S" in the S column. Press ENTER.
5	On the HIRFDET screen, if you are correcting a referral before batch processing, make any necessary changes. If you are updating ending employment information, complete the following fields: ♦ EMPLOYMENT END DATE: Enter date of ending employment in MM/DD/CCYY format. Entering a date will automatically move you to the COBRA AVAIL: field where an entry is mandatory. ♦ COBRA AVAIL: Enter applicable COBRA code. Valid options are: "Y" (yes), "N" (no), or "U" (unknown). **Note:** If an entry is made in the COBRA AVAIL: field when there is no entry in the EMPLOYMENT END DATE: field, the on-line error message "END DATE IS REQUIRED WHEN COBRA AVAIL IS ENTERED" will appear at the bottom of the screen. Press PF04=UPDATE.
6	To exit the HIRFDET screen, press: ♦ PF06=LIST to return to the list screen to view the added referral, or ♦ PF12=TD03 to return to the TD03 screen in ABC.

Deleting a HIPP Referral the Same Day

To delete an existing HIPP referral before the nightly batch processing, use the following step/action chart.

Step	Action
1	Access the case on ABC.
2	Go to the TD03 screen of the person whose HIPP referral needs to be deleted. Press PF06=LIST.
3	On the HREF menu screen, select HIPP referral by entering an "X." Press ENTER.
4	On the HIRFLST screen, select the referral that needs to be deleted by entering an "S" in the S column. Press ENTER.
5	On the HIRFDET screen, press PF09=DELETE. The on-line message: "PRESS PF09 AGAIN TO DELETE THE REFERRAL" will appear at the bottom of the screen. If deletion of the referral is intended, press PF09=DELETE again to complete the deletion. The on-line message: "REFERRAL HAS BEEN DELETED" will appear at the bottom of the screen. Attempting to delete a referral entered before the current date will produce the message, "REFERRAL CANNOT BE DELETED, ALREADY PROCESSED BY HIPP." **Note:** The referral information continues to be displayed on the HIRFDET screen after deletion of the referral is complete. If you choose, press PF06=LIST to view that the referral no longer exists on the HIRFLST screen. To exit the HIRFDET screen, press: ♦ PF06=LIST to return to the list screen to view the added referral, or ♦ PF12=TD03 to return to the TD03 screen in ABC.

Viewing Existing HIPP Referrals

To view existing HIPP referrals, use the following step/action chart.

Step	Action
1	Access the case on ABC.
2	Go to the TD03 screen of the person whose HIPP referral needs to be viewed. Press PF06=LIST.
3	On the HREF menu screen, select HIPP referral by entering an "X." Press ENTER.
4	The HIRFLST screen displays all referrals made for this person. To view more details on a referral, select the referral by entering an "S" in the S column. Press ENTER and go to next step. To exit the HIRFLST screen, press PF12=TD03 to return to the TD03 screen in ABC.
5	The HIRFDET screen displays the referral information. (See HIRFDET = HIPP Policyholder Referral Information Screen for more information).
6	To exit the HIRFDET screen, press: ♦ PF06=LIST to return to the list screen to view the added referral, or ♦ PF12=TD03 to return to the TD03 screen in ABC.

hawk-i Referral Screens

The ***hawk-i*** referral screens are used to:

- ♦ Refer children who:
  - Are eligible for only Medically Needy with a spenddown, or
  - Are voluntarily excluded from the Medicaid eligible group due to their income or resources.
- ♦ Reflect the ***hawk-i*** referrals case history.

HWKR = Identification of People in the Home Screen

```
HWKR                          IDENTIFICATION OF PEOPLE IN THE HOME
CASE:                              LAST:                          FIRST:
IN-THE      CHILD      MEDICAL      FIRST      LAST      AGE      CIT      REL      INS
HOME        REFERRED   END-DATE     NAME       NAME
-           -          MM DD CCYY   XXXXXX     XXXXX     XXX      XXXXXXX  XXX      X




PF01=STOP   PF02=ADDREF    PF03=MENU    PF04=TD03    PF05=INCOME    PF06=COMMENTS
PF07=INDIVIDUALS    PF08=BACK    PF09=FORWARD    PF10=REOPEN    PF11=DELETE REFERRAL
```

The HWKR = Identification of People in the Home screen displays a maximum of 16 people associated with the case. This screen contains the following fields:

- **CASE:** The ABC system's case number associated with the person the referral was made on.
- **LAST:** Last name of the case name on ABC.
- **FIRST:** First name of the case name on ABC.
- **IN-THE HOME:** This field is used to indicate which people listed are living together.
- **CHILD REFERRED:** This field is used to indicate each child being referred to ***hawk-i***.
- **MEDICAL END DATE:** The MEDICAL END DATE: field is displayed when a user selects "HAWK-I REFERRAL ON CANCELED CASE OR CHILD" or "HAWK-I REFERRAL ON A VOLUNTARILY EXCLUDED CHILD" and shows the negative date from the TD05 screen.
- **MEDICAL APP DATE:** The MEDICAL APP DATE: field is displayed when a user selects "HAWK-I REFERRAL ON DENIED APPLICATION OR CHILD" and shows the application date.
- **FIRST NAME:** Person's first name from the TD03 screen on ABC.
- **LAST NAME:** Person's last name from the TD03 screen on ABC.

- **AGE:** Age of the person as of the current date.
- **CIT:** Person's citizenship status as indicated in the CIT field on the person's ABC TD03 screen.
- **REL:** Relationship of listed individuals to the head of household. This field translates the code that is on the REL field on the ABC TD03 screens.
- **INS:** Indicates if the person in the home has health insurance coding on the ABC system. If there is health insurance coding on ABC, the entry in this field is "Y." If there is no health insurance coding on ABC, this field is blank.

The function keys available on the HWKR = Identification of People in the Home screen are:

PF01 = STOP	Allows you to leave both the HREF = Referral System and the ABC system.
PF02 = ADDREF	Submits the ***hawk-i*** referral.
PF03 = MENU	Returns you to the Iowa Referral Systems Menu screen.
PF04 = TD03	Returns you to the ABC TD03 screen from which you began the referral process.
PF05 = INCOME	Displays the Household Income From IABC-BCW2 screen where you enter income information for the household members.
PF06 = COMMENTS	Displays a Comments screen where information can be entered regarding the household that may be useful for the ***hawk-i*** eligibility worker.
PF07 = INDIVIDUALS	Displays the Identification of People in the Home screen that shows all of the people in the household.
PF08 = BACK	Used to view the previously viewed HWKR screen.
PF09 = FORWARD	Used to move to the next HWKR screen.
PF10 = REOPEN	Used to make a change in a ***hawk-i*** referral the same day it was submitted.
PF11 = DELETE REFERRAL	Used to delete a referral the same day it was submitted.

HWKR = Household Income From IABC-BCW2 Screen

The HWKR = Household Income From IABC-BCW2 Screen displays income information you enter for the household members.

```
HWKR                          HOUSEHOLD INCOME FROM IABC-BCW2                    MM/DD/YY
CASE: XXXXXX  XX  X  X            LAST: XXXXXX                  FIRST:  XXXX
NRLS MNTHLY PRORATED AMT  0000000  00          LAST MONTH OF PRORATION   MMYY
IF MORE THAN ONE LUMP-SUM EXPLAIN IN COMMENTS
INDIVIDUAL INCOME FOR:   LAST:  XXXXXX                FIRST:  XXXXX
SELF EMPLOYED Y/N                          DEPRECIATION AMOUNT 0000000   00
            EMPLOYER:
TYPE OF INCOME:  XXXXXXXX                          AMOUNT:   0000.00
PRESS PF09 FOR MORE INCOME RECORDS

PF01=STOP     PF02=ADDREF     PF03=MENU     PF04=TD03     PF05=INCOME     PF06=COMMENTS
PF07=INDIVIDUALS     PF08=BACK     PF09=FORWARD     PF10=REOPEN     PF11=DELETE REFERRAL
```

This screen contains the following fields:

- **CASE:** The ABC system's case number associated with the person the referral was made in.
- **LAST:** Last name of the person that is the case name on ABC.
- **FIRST:** First name of the person that is the case name on ABC.
- **NRLS MNTHLY PRORATED AMT:** Field used to enter the amount of any non-recurring lump sum income that is prorated monthly.
- **LAST MONTH OF PRORATION:** Field used to enter the last month of the non-recurring lump sum income proration period.
- **INDIVIDUAL INCOME FOR:**
  - **LAST:** Last name of the person with a BCW2 income record in ABC.
  - **FIRST:** First name of the person with a BCW2 income record in ABC.
- **SELF EMPLOYED Y/N:** Field used to indicate if the person is self-employed or not.

- **DEPRECIATION AMOUNT:** Field used to enter the amount of depreciation a self-employed person claims on their tax form Schedule C or F.
- **EMPLOYER:** Field used to enter the employer's name. If the employer's name is not known, enter UNK and explain on the COMMENTS screen.
- **TYPE OF INCOME:** Income type based on entries from the BCW2 income record. Earned income is listed as earned income. Unearned income is listed by source of income based on the coding in the SR (1-4) BCW2 fields.
- **AMOUNT:** Amount of earned or unearned income based on entries from the EARNED (1-4) and UNEARN (1-4) BCW2 fields.

HWKR = COMMENTS Screen

The HWKR = COMMENTS screen allows you to:

- Enter any comments that are appropriate for the referral you are making; or
- View any comments associated with the case referral.

```
HWKR                          COMMENTS
CASE: XXXXXX  XX  X  X        LAST:  XXXX          FIRST:  XXXX
POLICYHOLDER NAME:                          AP      YES:        NO:
COMMENTS:




                                  WORKER INFORMATION
      NAME                        COUNTY                    PHONE
XXXXXXX    XXXX                   77-1                  XXX-XXX-XXXX
WORKER EMAIL: XXXXXX   @ dhs.state.ia.us

PF01=STOP     PF02=ADDREF    PF03-MENU    PF04-TD03    PF05=INCOME    PF06=COMMENTS
PF07=INDIVIDUALS     PF08=BACK     PF10=REOPEN    PF11=DELETE REFERRAL
```

This screen includes the following fields:

- **CASE:** The ABC system's case number associated with the person on whom the referral was made.
- **LAST:** Last name of the case name on ABC.
- **FIRST:** First name of the case name on ABC.
- **POLICYHOLDER NAME:** Field used to enter the first and last name of the health insurance policyholder.
- **AP YES:** Enter an "X" if the policyholder is an absent parent.
- **AP NO:** Enter an "X" if the policy is not an absent parent.
- **COMMENTS:** Additional information and comments concerning the referral.

Under the section WORKER INFORMATION, the system generates from the WKER file the worker's name, county number, phone number, and the worker's e-mail address based on the county number and worker identification number.

The function keys available on the HWKR = COMMENTS screen are:

PF01 = STOP	Allows you to leave both the HREF = Referral System and the ABC system.
PF02 = ADDREF	Submits the ***hawk-i*** referral.
PF03 = MENU	Returns you to the Iowa Referral Systems Menu screen.
PF04 = TD03	Returns you to the ABC TD03 screen from which you began the referral process.
PF05 = INCOME	Displays the Household Income From IABC-BCW2 screen where you enter income information for the household members.
PF06 = COMMENTS	Is not a valid function while on the COMMENTS screen.
PF07 = INDIVIDUALS	Displays the Identification of People in the Home screen that shows all of the people in the household.
PF08 = BACK	Used to view the previously viewed HWKR screen.
PF09 = FORWARD	Used to move to the next HWKR screen.
PF10 = REOPEN	Used to make a change in a ***hawk-i*** referral the same day it was submitted.
PF11 = DELETE REFERRAL	Used to delete a referral the same day it was submitted.

HWKR = HISTORY Screen

The HWKR = HISTORY screen displays the referral history with the oldest referral displayed first. The history starts with the identification of the people in the home, the BCW2 income, and any comments associated with the referral.

```
HWKR      HISTORY          IDENTIFICATION OF PEOPLE IN THE HOME          AS OF     MM/DD/YY
CASE:                            LAST:                                 FIRST:
IN-THE      CHILD      MEDICAL     FIRST     LAST      AGE      CIT        REL      INS
HOME        REFERRED   END-DATE    NAME      NAME
X             X        MM DD CCYY  XXXXXX    XXXXX     XXX      XXXXXXX    XXX      X




PF01=STOP      PF03=MENU      PF04=TD03      PF05=INCOME      PF06=COMMENTS
PF07=INDIVIDUALS      PF08=BACK      PF09=FORWARD
```

This screen displays the same fields as the HWKR=Identification of People in the Home Screen. See HWKR = Identification of People in the Home Screen for a description of the fields.

The function keys available are:

PF01 = STOP	Allows you to leave both the HREF = Referral and ABC Systems.
PF03 = MENU	Returns you to the Iowa Referral Systems Menu screen.
PF04 = TD03	Returns you to the ABC TD03 screen where you began the referral process.
PF05 = INCOME	Displays the Household Income From IABC-BCW2 screen where you entered income information for the household members.
PF06 = COMMENTS	Displays the COMMENTS screen where information previously entered regarding the household can be viewed.
PF07 = INDIVIDUALS	Returns to the Identification of People in the Home for the oldest referral.
PF08 = BACK	Moves to the individual, income, or comments for the referral.
PF09 = FORWARD	Moves to the next individual, income, or comments for the referral.

***hawk-i* Referral Case Actions**

Whenever notice reason 205 is generated on a case in the 92-0 aid type, the worker to whom the case is assigned on the case master file will receive a WIFS message by e-mail reminding the worker that a referral to ***hawk-i*** may need to be completed.

Complete a ***hawk-i*** referral even if the children are:

- Insured, or
- Living in families whose income exceeds 133% of the federal poverty level for the family size, regardless of how much over 133% the family income is, or
- Dependents of state of Iowa employees. (See 8-B and 8-G, REFERRALS TO THE ***hawk-i*** PROGRAM.)

Note: Form 470-3565, *Referral to the* ***hawk-i*** *Program*, must be completed if:

- The children being referred are currently active for Medicaid; or
- The family of the children you are referring has people who:
  - Must be marked as "In The Home" but do not show up on the Individual screen because they do not have a TD03 record, or
  - Show up on the Individual screen but their income does not show up because they do not have a BCW2 income record.

1. Mrs. A files a Medicaid application for her children April 4. It is processed June 6. The children are denied Medicaid for the months of April and May due to excess income. The children are approved for Medicaid for June and ongoing months. Because the children are active for Medicaid, the ***hawk-i*** referral for May coverage cannot be made via the automated process. A paper referral must be made.

2. Same as Example 1, except that the children are approved for Medicaid for the months of April and May and are denied for June and ongoing months due to excess income.

   The ***hawk-i*** referral for June and ongoing months **can** be made via the automated process because the children being referred are not active for Medicaid. The worker makes the referral using the referral type of "Canceled Case or Child," since Medicaid was approved for some months and then "canceled," even though the *Notice of Decision* says that the application was denied.

3. Ms. C and her children, ages 2 years and 5 years, receive Medicaid under MAC. Ms. C is pregnant. Ms. C reports new income that exceeds 133% of poverty but does not exceed 200%. So, Ms. C remains Medicaid eligible. The status of her children changes from active to considered persons.

   The ***hawk-i*** referral for the children can be made via the automated process using the referral type of "Canceled Case or Child." However, on the "Identification of People in the Home" screen, the MEDICAID END DATE column will contain zeros for the dates for the children. This is because the system only changed the status of the children. The worker will need to enter the MEDICAID END DATE for the children being referred.

   Note: In this situation, because notice reason 205 was not generated, the worker will not receive a WIFS e-mail reminder to do a referral and the *Notice of Decision* will not have the ***hawk-i*** language on it.

Making an Automated *hawk-i* Referral

Automated ***hawk-i*** referrals must be made no later than the end of the system month following the month of the NEGATIVE DATE on TD05. Otherwise, the referral must be made using the manual process. Do not complete an automated ***hawk-i*** referral the same day as other ABC transactions are created on the same case. Allow other transactions to update successfully before making the ***hawk-i*** referral.

To make an automated ***hawk-i*** referral, use the following step/action chart.

Step	Action
1	Access the case on ABC.
2	Go to the TD03 screen of any person associated with the case. Press PF06=REF MENU.
3	On the HREF menu screen, enter an "X" in the select column by the referral type under which the referral is being made. Press ENTER. **Note:** Pressing ENTER creates transactions. Moving on to other steps in the referral process without pressing ENTER causes no transaction to be created. When you attempt to submit the referral, you will receive an error message. (See Step 12.)

Step	Action
	Referral types are: ♦ Canceled child or case. Use when the children being referred are losing full Medicaid eligibility due to excess income and will need to meet a spenddown under Medically Needy. ♦ Denied application or child. Use when denying Medicaid eligibility to children on an application due to excess income and the children will need to meet a spenddown under Medically Needy. ♦ Voluntarily excluded child – due to income. Use when referring a child who was voluntarily excluded due to the child's income. ♦ Voluntarily excluded child – due to resources. Use when referring a child who was voluntarily excluded due to the child's resources.
4	On the HWKR = Identification of People in the Home screen, complete the following fields: ♦ IN-THE HOME: Enter an "X" in this field for each person who lives in the home. (See the example following this chart.) Mark the following people as "In the Home": • Anyone who would be an eligible person or a considered person for the MAC coverage group. • Children who are voluntarily excluded from the Medicaid eligible group. • Undocumented or ineligible alien children under age 19. • Stepparents. DO NOT include children living in the home age 19 or older. DO NOT mark an SSI recipient as "In The Home" or as a "Child Referred." Explain family composition on the COMMENTS screen. ♦ CHILD REFERRED: Enter an "X" in this field for each child being referred. (See example following this chart.) **Note:** Failure to enter an "X" in the IN-THE HOME: field for the child causes an "X" to default into the IN-THE HOME: field when you enter an "X" in the CHILD REFERRED: field.

Step	Action
	♦ MEDICAL END-DATE: and MEDICAL APP-DATE: If the dates in these fields are incorrect or blank for a child being referred, enter the correct date. Do not attempt to correct the date for people not being referred or for people not marked as "in the home." ♦ INS: If there is a "Y" in this field, no further action is required. If blank, enter one of the codes below for people marked "in the home": • N No, this person does not have health insurance, or • Y Yes, this person has health insurance. If you enter "Y," go to the COMMENTS screen to enter the policyholder's name and whether or not the policyholder is an absent parent. Press ENTER. **Note:** If you attempt to submit a referral without codes in the INS field, you will RECEIVE an edit message stating, "Individuals in the home require an insurance code of 'Y' or 'N.'"
5	Move to the next HWKR screen by pressing PF09=FORWARD or PF05=INCOME.
6	On the HWKR = HOUSEHOLD INCOME FROM IABC-BCW2 screen, complete the following fields, if applicable: ♦ NRLS MNTHLY PRORATED AMT: Enter the prorated monthly amount of nonrecurring lump-sum income. **Do not** list prorated contract income or prorated recurring lump-sum income. Explain the circumstances surrounding these types of income on the COMMENTS screen. ♦ LAST MONTH OF PRORATION: Enter the last month of the nonrecurring lump sum income proration period in MMYY format. ♦ SELF EMPLOYED Y/N: If a person is self-employed, enter a "Y." If a person is not self-employed, leave blank. ♦ DEPRECIATION AMOUNT: Enter the amount of depreciation a self-employed person claims on tax form Schedule C or F. If the person claims no depreciation, leave zeros in the amount field.

Step	Action
	♦ EMPLOYER: A required field used to enter the name of the employer, if the type of income is earned income. The system uses the employer's name when printing the ***hawk-i*** annual review form and to identify dependents of the state of Iowa employees. Leave this field blank if the income is not earned income. Press ENTER.
7	If anyone else in the household has income, press PF09=FORWARD. Repeat Steps 5 and 6 until the message "You have reached the last income record for this case" appears at the bottom of the screen. Go to Step 8.
8	For referral of a canceled case or child or of a denied application or child, go to Step 10 if no additional comments are needed. If additional comments are needed, press PF06=COMMENTS and go to Step 9. For referral of child voluntarily excluded due to income or resources, the system will require you to go to the COMMENTS screen. Press PF06=COMMENTS. Go to Step 9.
9	On the COMMENTS screen, enter any additional information for the referral type selected. Press ENTER. For referral of a canceled case or child or of a denied application or child, include information such as household composition when there is an SSI member and whether the child is covered by any health insurance. For referral of child voluntarily excluded due to income or resources, include information about the income of the voluntarily excluded child and whether it has been verified. Include the following: ♦ Source of the income, ♦ Monthly amount of the income, ♦ A statement that the income has NOT been verified, and ♦ Any other information about the income you feel is important, including why the child was voluntarily excluded and if the child is covered under any health insurance.

Step	Action
	For referral of child voluntarily excluded due to resources: ♦ If the child has income, include the same information as required for a child voluntarily excluded due to income. ♦ If the child doesn't have income, include a statement to confirm the lack of income.
10	Press PF02=ADD REF to submit the referral.
11	If successful, the message "Success – Your referral will be sent this evening" will appear at the bottom of the screen. Go to Step 14.
12	If the message "Invalid Referral – Enter Employer name, 'Unknown' or 'N/A'" appears at the bottom of the screen, review the income screens using one of these options: ♦ From a Household Income from IABC-BCW2 screen, press PF08=BACK to scroll back through the income records, or ♦ From the Comments screen, press PF05=INCOME to return to the income screens and use PF09=FORWARD to scroll forward through the income screens. Look for records with the income type of earned income where the EMPLOYER: field is blank. Make the appropriate entries and press ENTER.
13	Press PF02=ADD REF to submit referral. If the referral is successful, go to Step 14. Otherwise, repeat Steps 12 and 13.
14	To exit from the automated referral system, press: ♦ PF04=TD03 to return to the ABC case on which the referral was completed, or ♦ PF03=MENU to return to the Menu screen. At the Menu screen, type the case number of the next case that needs to be referred to ***hawk-i*** and begin the referral process, or ♦ PF01=STOP to exit both the HREF and ABC systems. The message "Good Bye from HWKR – Have a Great Day!" will be displayed. To return to ABC, type "IABC" or to exit CICS, type "LOGOFF."

1. Family composition is Mr. and Mrs. S, and their two children, ages 3 months and 4 years. The 3-month-old child receives Medicaid as the newborn child of a Medicaid-eligible mother. All four people should be marked as "in the home" but only the 4-year-old should be marked as a "child referred."

   If the family continues to be over 133% of poverty when the newborn turns age 1, a new ***hawk-i*** referral should be completed. The referral should list the parents and the other sibling as "in the home" but list only the 1-year-old as a "child referred," and should contain notes explaining the situation.

2. Mr. M's children receive Medicaid under MAC. Medicaid is canceled effective May 31, 2004, for failure to return an annual review form. The *Notice of Decision* is dated May 12, 2004. The negative date on TD05 is 05-31-04.

   On May 24, 2004, Mr. M returns a complete annual review form. The worker attempts to reinstate Medicaid using a new amount of projected income. However, the new income amount exceeds 133% of poverty. The case remains canceled and a new *Notice of Decision* is generated. This action causes a new negative date of 06-30-04 to be displayed on TD05.

   When the worker makes the automated ***hawk-i*** referral, the MEDICAL END DATE will show 06-30-04. The worker must change the date to 05-31-04 to reflect the correct date on which Medicaid ended. If the date is NOT changed, ***hawk-i*** coverage would incorrectly begin July 1, 2004 and the children would not have coverage under ***hawk-i*** or Medicaid for the month of June.

Changing a *hawk-i* Referral the Same Day

You can make changes in an automated ***hawk-i*** referral the same day it was submitted. Use the following step/action chart.

Step	Action
1	Access the case on the ABC system.
2	Go to any TD03 screen for the case.
3	Press PF06=REF MENU.

Step	Action
4	On the HREF menu screen, type an "X" in the select column by the referral type you used earlier to make the original referral. Press ENTER.
5	On the Identification of People in the Home screen, press PF10=REOPEN.
6	Make any changes needed. Press ENTER before proceeding to the next step in the referral process.
7	Once all changes have been made, press PF02=ADD REF.
8	To exit from the automated referral system, press: ♦ PF04=TD03 to return to the ABC case on which the referral was completed, or ♦ PF03=MENU to return to the Menu screen. At the Menu screen, type the case number of the next case that needs to be referred to ***hawk-i*** and begin the referral process, or ♦ PF01=STOP to exit both the HREF and ABC systems. The message "Good Bye from HWKR – Have a Great Day!" will be displayed. To return to ABC, type "IABC" or to exit CICS, type "LOGOFF."

Changing a *hawk-i* Referral After the Day of Referral

If you need to make a change on an automated ***hawk-i*** referral on a day other than the day it was referred, use one of these procedures:

- Contact ***hawk-i*** Customer Service at 1-800-257-8563. Be sure to identify yourself as an income maintenance worker. This will prevent the customer service representative from requesting a signed release of information from the client before talking to you.
- To correct information already submitted in an automated referral, make a new complete automated referral with corrected information. Enter "Corrected Referral" in the COMMENTS: section, and a brief, but complete, comment about what was corrected.

Deleting a *hawk-i* Referral the Same Day

You can delete an automated ***hawk-i*** referral the same day it was submitted. Use the following step/action chart.

Step	Action
1	Access the case on ABC.
2	Go to any TD03 screen for the case. Press PF06=REF MENU.
3	On the HREF menu screen, type an "X" in the select column by the referral type you used earlier to make the original referral. Press ENTER.
4	On the Identification of People in the Home screen, press PF11=DELETE REFERRAL. The message "Success – Your referral record has been deleted" will appear at the bottom of the screen.
5	To exit from the automated referral system, press: ♦ PF04=TD03 to return to the ABC case on which the referral was completed, or ♦ PF03=MENU to return to the Menu screen. At the Menu screen, type the case number of the next case that needs to be referred to ***hawk-i*** and begin the referral process, or ♦ PF01=STOP to exit both the HREF and ABC systems. The message "Good Bye from HWKR – Have a Great Day!" will be displayed. To return to ABC, type "IABC" or to exit CICS, type "LOGOFF."

Deleting a *hawk-i* Referral After the Day of Referral

If an automated ***hawk-i*** referral needs to be deleted on a day other than the day it was submitted, contact ***hawk-i*** Customer Service at 1-800-257-8563. Be sure to identify yourself as an income maintenance worker. This will prevent the customer service representative from requesting a signed release of information from the client before talking to you.

Viewing *hawk-i* Referral History

To view a history of the automated referrals made on a case, use the following step/action chart.

Step	Action
1	Access the case on ABC.
2	Go to any TD03 screen for the case. Press PF06=REF MENU.
3	On the HREF menu screen, type an "X" in the select column by "Hawk-i View Referral History." Press ENTER.
4	At the HWKR = History screen, press PF09=FORWARD to go to the next referral. Continue through all referrals by pressing PF09. When the last referral is reached, the message "You have reached the last history record" will appear at the bottom of the screen.
5	Press the PF08=BACK key to return to a previous history record. When the oldest record is reached, the message "You have reached the first history period" will appear at the bottom of the screen.
6	To exit from the automated referral system, press: ♦ PF04=TD03 to return to the ABC case on which the referral was completed, or ♦ PF03=MENU to return to the Menu screen. At the Menu screen, type the case number of the next case that needs to be referred to ***hawk-i*** and begin the referral process, or ♦ PF01=STOP to exit both the HREF and ABC systems. The message "Good Bye from HWKR – Have a Great Day!" will be displayed. To return to ABC, type "IABC" or to exit CICS, type "LOGOFF."

MANAGED HEALTH CARE SYSTEMS

This section discusses the Managed Health Care (MHC) System. Income maintenance workers do not make system entries. The MHC administrative contractor makes those entries.

Traditionally, Medicaid-eligible recipients have been entitled to all medical services in the state's Medicaid plan if those services are received from a provider willing to accept the established fee as payment in full. However, alternative means by which recipients receive their medical services are becoming increasingly important.

The managed health care code (MHC CD) on the SSNI screen designates the type of alternate delivery organization in which the client participates. The code may reflect the client's participation in one or more of the following Medicaid programs:

- Health maintenance organization (HMO)
- Iowa Plan for Behavioral Health (implemented January 1999)
- Medicaid Patient Access to Services System (MediPASS)
- Lock-in program

See SSNI = MEDICAID ELIGIBILITY FILE, for a list of the managed health care status codes. Policy information, including definitions of county types (voluntary, default, or mandatory) and the counties involved with managed health care, is covered in 8-M, MANAGED HEALTH CARE.

Health Maintenance Organizations

A health maintenance organization (HMO) is a group of medical providers that has contracted with the Department to serve Medicaid recipients who enroll in the HMO. The HMO Medicaid alternative differs from traditional Medicaid in that a capitation payment is paid to the HMO on the recipient's behalf for each month the recipient is eligible to receive Medicaid services through the HMO.

This capitation payment is calculated to be less than the fee-for-service (regular Medicaid) cost experience. The rate covers all contracted services, regardless of how often the services are used by the recipient. The capitation payment is considered payment for medical services and is subject to overpayment recovery.

Recipients are enrolled in an HMO through entries made to the ABC system that are sent over the Medicaid Eligibility System. If the SSNI screen does not show a recipient as enrolled in an HMO, the HMO does not receive a capitation payment for the recipient.

Iowa Plan for Behavioral Health

The Iowa Plan for Behavioral Health (Iowa Plan) is a statewide Medicaid managed care plan for mental health and substance abuse treatment services. The Iowa Plan contractor, Magellan Behavioral Care of Iowa, operates under a capitated, risk-based contract.

A capitation payment is paid to contractor for each month the recipient is eligible to receive Medicaid services through the Iowa Plan. The capitation payment is considered payment for medical services and is subject to overpayment recovery.

Medicaid beneficiaries enrolled with the Iowa Plan must access mental health and substance abuse treatment services through providers that have contracted with Magellan Behavioral Care of Iowa to provide Iowa Plan Medicaid services.

Enrollment with the Iowa Plan is mandatory. The Medicaid Eligibility system automatically generates enrollment when Medicaid eligibility is initially identified for each month. Iowa Plan enrollment is designated on the SSNI screen in the MHC CODE column. Any letter in the MHC CODE column designates Iowa Plan enrollment. A number designates that the client is not enrolled with the Iowa Plan.

Enrollment begins with the month of application and does not cover months of retroactive Medicaid eligibility. Exceptions:

- For recipients residing in a substance-abuse-licensed PMIC or a child or adolescent treatment unit at Cherokee MHI or Independence MHI, enrollment begins with the month of admission, even when that is a month of retroactive Medicaid eligibility.
- For recipients whose Medicaid eligibility is based on determination of SSI, enrollment will not be granted for months before the Department receives notice from the State Data Exchange of the person's new SSI eligibility.

Once determined, enrollment may not be altered for current or past months of service, and may not be updated through Quality Assurance. Changes or corrections to ABC affect future months of enrollment only.

Most Medicaid recipients under the age of 65 are enrolled with the Iowa Plan. The following are excluded from enrollment:

- People who are medically needy with a cash spenddown.
- People residing at Glenwood or Woodward Resource Centers.
- People whose Medicaid benefit package is limited, such as QMB or SLMB recipients, presumptive eligibles, and illegal aliens.

When a Medicaid beneficiary is NOT enrolled with the Iowa Plan, the Medicaid fee-for-service program covers mental health and substance abuse treatment Iowa services in accordance with regular Medicaid (fee-for-service) program policies and procedures.

Patient Management

Medicaid Patient Access to Service System (MediPASS) is a program in which primary-care physicians enrolled for Medicaid agree to serve as a managed health care provider (called a patient manager) for enrolled recipients.

Under MediPASS, the Medicaid recipient selects or is assigned one primary care physician to be the recipient's patient manager. This physician is responsible for authorizing payment to other providers and monitoring necessary medical care. Care provided by other medical providers without the authorization of the patient manager is not payable under Medicaid.

MediPASS is not a capitation program like a health maintenance organization. All providers who give properly authorized service to the recipient are paid on a fee-for-service basis, including the patient manager. The patient manager receives a monthly "management" fee for each enrolled recipient, in addition to the normal fee-for-service reimbursement.

See MEDIPASS PROVIDER ON-LINE DISPLAY (PROV), for instructions on how to access information on physicians enrolled as patient health managers.

Notices to Potential and Enrolled Recipients

The managed health care contractor generates most notices regarding managed health care activity. However, the ABC system automatically generates a managed health care notice when:

- Medicaid is canceled.
- Health care coverage that includes Medicare is coded onto the ABC system.
- The aid type is changed to a group excluded from managed health care, as defined in 8-M, Who Is Enrolled or Enrollment.
- The recipient's county is changed to one not in the enrollment area covered by the previous managed health care provider.

See 14-B-Appendix, NOTICE CODES, for notices ABC issues on managed health care activity. The IM worker gets copies of these notices.

The managed health care contractor sends notices with a standard template when a recipient:

- Is due to be enrolled or is forced into enrollment.
- Changes enrollment from one managed health care option or provider to another.
- Moves to a county designated as mandatory or default for managed health care enrollment.

The managed health care contractor also sends notices when any of the following occurs:

- A recipient disenrolls from managed health care by choice. (In mandatory counties, this requires approval of the Managed Health Care Review Committee. It is allowed without approval in voluntary counties.)
- The Managed Health Care Review Committee approves a provider's request to disenroll a recipient from managed health care.
- The Managed Health Care Review Committee denies a request for disenrollment.
- A person with an excluded aid type makes a request for enrollment on form 470-2168, *Managed Health Care Enrollment Form*.

- A person living in a nonparticipating county makes a request for enrollment on form 470-2168, *Managed Health Care Enrollment Form*.

Note: Because each instance is reviewed individually, no standard template is used.

MEDIPASS PROVIDER ON-LINE DISPLAY (PROV)

The purpose of the Provider Informational Inquiry System (PROV) is to display eligible MediPASS providers so the client may select one provider for a case or a different provider for each individual. To sign on to PROV, see 14-B(4), Signing on to the ABC System. After receiving the IABC MENU, enter PROV for the option and press ENTER key.

```
PROV                          DEPARTMENT OF HUMAN SERVICES
                          MANAGED HEALTH CARE PROVIDER INQUIRY
                                       MENU


        1.   DISPLAY PROVIDER INFORMATION USING PROVIDER NUMBER
        2.   LIST PROVIDERS BY NAME WITHIN COUNTY
        3.   LIST PROVIDERS BY PROVIDER TYPE WITHIN COUNTY

                    SELECT: X  (ENTER 1 THRU 3)

SERVICE COUNTY NUMBER: xx                    PROVIDER NUMBER: xxxxxxx

PROVIDER LAST NAME: xxxxxxxxxxxxxx           PROVIDER TYPE: xx

FOR SELECTION 1 ENTER ONLY THE PROVIDER NUMBER.
      WILL DISPLAY ALL AVAILABLE INFORMATION FOR THAT PROVIDER.
FOR SELECTION 2 ENTER THE COUNTY NUMBER AND THE LAST NAME OF THE PROVIDER.
      WILL LIST PROVIDER NAMES AND PROVIDER NUMBERS FOR THAT COUNTY.
FOR SELECTION 3 ENTER THE COUNTY NUMBER AND THE PROVIDER TYPE.
      WILL LIST PROVIDER NAMES AND PROVIDER NUMBERS FOR THE SELECTED TYPE.
            (EXAMPLE OF PROVIDER TYPES: GP, FP, OB, IN, PD)
*** 1=STOP      3=NEXT SCREEN                          CD/SCRN: X XXXX
xxxxxxxxxxxxxxxxxxxxx ERROR/ INFORMATIONAL MESSAGES xxxxxxxxxxxxxxxxxxxx
```

Use the PROV Menu screen as follows:

- For selection 1, enter the provider number field only.
- For selection 2, enter the service county number and the provider last name field. If the last name is not entered, the program will start with the first provider for the county selected.
- For selection 3, enter the service county number and the provider type.
- Return to the originating ABC screen by making a CD entry of 3 and SCRN entry of IABC or LINK.

PROV Selection 1 Screen

The PROV Selection 1 screen gives specific information about a provider.

```
PROV                          DEPARTMENT OF HUMAN SERVICES
                        MANAGED HEALTH CARE PROVIDER DISPLAY SCREEN

NAME:  xxxxxxxxxxxxxxxxxxxxxxxxxxx                PROVIDER TYPE: xx
OTHER CO SERVED: xx xx xx

CO: XX   PROVIDER NUMBER: xxxxxxx                 ADDRESS: xxxxxxxxxxxxxxxxxxxxxxxxx
24  HOUR PHONE:  (xxx) xxx-xxxx                             xxxxxxxxxxxxxxxxxxxxxxxxx
EFFECTIVE START DATE:  xx xx xx                             xxxxxxxxxxxxxxx xxxxx-xxxx
MAXIMUM NO. OF CLIENTS: xxxx                          TOTAL NO. OF CLIENTS: xxxx

CO: XX  PROVIDER NUMBER: xxxxxxx                  ADDRESS:    xxxxxxxxxxxxxxxxxxxxxxxxx
24  HOUR PHONE: (xxx) xxx-xxxx                              xxxxxxxxxxxxxxxxxxxxxxxxx
EFFECTIVE START DATE: xx xx xx                              xxxxxxxxxxxxxxx xxxxx-xxxx
MAXIMUM NO. OF CLIENTS: xxxx                          TOTAL NO. OF CLIENTS: xxxx

CO: XX  PROVIDER NUMBER: xxxxxxx                  ADDRESS:    xxxxxxxxxxxxxxxxxxxxxxxxx
24  HOUR PHONE: (xxx) xxx-xxxx                              xxxxxxxxxxxxxxxxxxxxxxxxx
EFFECTIVE START DATE: xx xx xx                              xxxxxxxxxxxxxxx xxxxx-xxxx
MAXIMUM NO. OF CLIENTS: xxxx                          TOTAL NO. OF CLIENTS: xxxx
*** 1=STOP       3=NEXT SCREEN     4=MORE DATA                        CD/SCRN: x xxxx
SELECT: x        SERV CO: xx     PROV: xxxxxxx          TYPE: xx          LST NME: xxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxxxx ERROR/ INFORMATIONAL MESSAGES xxxxxxxxxxxxxxxxxxxx
```

The information displayed includes:

- The provider's name.
- The provider's specialty type.
- The other counties that the provider will serve.
- The county where the provider's office is located.
- The provider's Medicaid vendor number.
- The 24-hour phone number at which the provider can be reached.
- The date that the provider started working with Medicaid clients.
- The address of the provider's office.
- The total number of clients for which the provider has agreed to act as health manager.
- The total number of clients currently enrolled with this provider.

A provider may work out of more than one office. The screen has been designed to display up to three office locations. If the provider has more than three office locations, the remaining locations may be viewed by using the option (4=MORE DATA).

Navigate to another screen as follows:

- For PROV selection 1, enter the provider number field only.
- For PROV selection 2, enter the service county number and the provider's last name. If no last name is entered, the program will start with the first provider for the county selected.
- For PROV selection 3, enter the service county number and the provider type.
- Return to the PROV MENU screen using the PF1 key.
- Return to the originating ABC screen by making a CD entry of 3 and SCRN entry of IABC or LINK.

PROV Selection 2 Screen

The PROV Selection 2 screen displays a list of providers for a specific county in name order. The information displayed is the provider's name, specialty type, and number. Up to 32 providers are displayed.

```
PROV                          DEPARTMENT OF HUMAN SERVICES
                     MANAGED HEALTH CARE PROVIDER NAME FOR COUNTY XX

NAME                         TYPE NUMBER   NAME                         TYPE NUMBER
xxxxxxxxxxxxxxxxxxxxxxxxxxx   xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxx      xx xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxx   xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxx      xx xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxx   xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxx      xx xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxx   xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxx      xx xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxx   xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxx      xx xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxx   xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxx      xx xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxx   xx xxxxxxx   xxxxxxxxxxxxxxxxxxxxxxxx      xx xxxxxxx
***  1=STOP        3=NEXT SCREEN     4=MORE DATA               CD/SCRN: x xxxx
SELECT: x        SERV CO: xx     PROV: xxxxxxx      TYPE: xx    LST NME: xxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxxxxx ERROR/ INFORMATIONAL MESSAGES xxxxxxxxxxxxxxxxxxxxx
```

To find the rest of the provider's information, use option 1 and enter the provider's number. If there are more providers to be displayed, the remaining providers may be viewed by using option 4=MORE DATA.

Navigate to another screen as follows:

- For PROV selection 1, enter the provider number field only.
- For PROV selection 2, enter the service county number and the provider's last name. If no last name is entered, the program will start with the first provider for the county selected.
- For PROV selection 3, enter the service county number and the provider type.
- Return to the PROV MENU screen using the PF1 key.
- Return to the originating ABC screen by making a CD entry of 3 and SCRN entry of IABC or LINK.

PROV Selection 3 Screen

The PROV Selection screen displays a list of providers for a specific county and provider specialty. The information displayed on this screen is the provider's name and the provider's number. Up to 32 providers are displayed.

```
PROV                         DEPARTMENT OF HUMAN SERVICES
                 MANAGED HEALTH CARE PROVIDER TYPE XX FOR COUNTY xx

NAME                               NUMBER   NAME                            NUMBER
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx  xxxxxxxxxxxxxxxxxxxxxxxxxx      xxxxxxx
***  1=STOP      3=NEXT SCREEN      4=MORE DATA                    CD/SCRN: x xxxx
SELECT: x     SERV CO: xx    PROV: xxxxxxx       TYPE: xx        LST NME: xxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxxxxx ERROR/ INFORMATIONAL MESSAGES xxxxxxxxxxxxxxxxxxxxx
```

To find the rest of the provider's information, use option 1 and enter the provider's number. If there are more providers to be displayed, the remaining providers may be viewed by using option 4=MORE DATA.

Navigate to another screen as follows:

- For PROV selection 1, enter the provider number field only.
- For PROV selection 2, enter the service county number and the provider's last name. If no last name is entered, the program will start with the first provider for the county selected.
- For PROV selection 3, enter the service county number and the provider type.
- Return to the PROV MENU screen using the PF1 key.
- Return to the originating ABC screen by making a CD entry of 3 and SCRN entry of IABC or LINK.

MEPD BILLING SCREENS

The following sections explain:

MEPD Main Menu Screen

The MEPD Main Menu shows a list of the available MEPD screens.

```
                        IOWA DEPARTMENT OF HUMAN SERVICES          DATE: MM/DD/YY
                                  MEPD MAIN MENU

                          X   SUMM     MEPD SUMMARY
                          X   DETL     MEPD DETAIL
                          X   PREF     UNPROCESSED PAYMENTS/REFUNDS
                          X   RETR     RETRO SCREEN
                          X   STMT     BILLING STATEMENT




NEXT SCREEN XXXX                                  PF12=SSNI, CLEAR=QUIT
```

The MEPD Main Menu can be accessed the following ways:

- From a blank screen, enter MEPD.
- From the SSNI SELECTION menu by pressing the PF12 key.
- From any of the MEPD screens by pressing the PF1 key.

Place an 'X' in front of the screen you wish to view **or** enter a four-letter screen name of SUMM, DETL, PREF, RETR, or STMT in the NEXT SCREEN field and press the ENTER key.

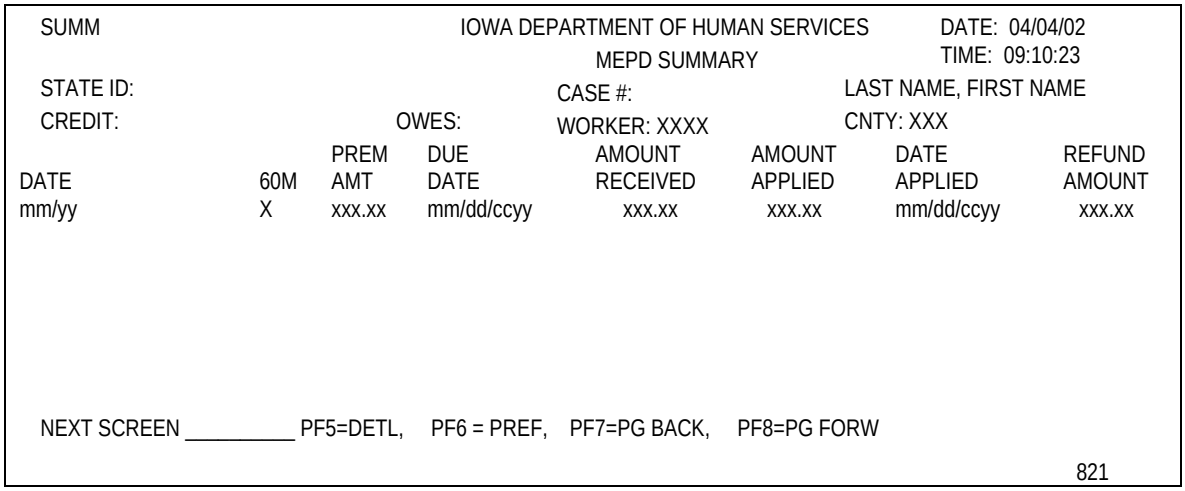
Screen field descriptions:

- **SUMM** is the field to access the SUMM screen.
- **DETL** is the field to access the DETL screen.
- **PREF** is the field to access the PREF screen.
- **RETR** is the field to access the RETR screen.
- **STMT** is the field to access the STMT screen.
- **NEXT SCREEN** is the field to move you to another screen name in the MEPD system.
- **PF12=SSNI** is the function key to transfer to the SSNI Selection Menu.
- **CLEAR=QUIT** is the key to move you out of the MEPD screen.

SUMM = MEPD Summary Screen

The SUMM screen shows a summary for each month of the premium amount, the amount applied, and the last activity date. The SUMM screen can be accessed the following ways:

- From the MEPD MENU by placing an 'X' by the SUMM field and pressing the ENTER key.
- From any MEPD screen by typing SUMM in the NEXT SCREEN field and pressing the ENTER key.
- From the DETL screen by pressing the PF5 key.
- From the PREF screen by pressing the PF6 key.



SUMM IOWA DEPARTMENT OF HUMAN SERVICES DATE: 04/04/02
MEPD SUMMARY TIME: 09:10:23
STATE ID: CASE #: LAST NAME, FIRST NAME
CREDIT: OWES: WORKER: XXXX CNTY: XXX

DATE	60M	PREM AMT	DUE DATE	AMOUNT RECEIVED	AMOUNT APPLIED	DATE APPLIED	REFUND AMOUNT
mm/yy	X	xxx.xx	mm/dd/ccyy	xxx.xx	xxx.xx	mm/dd/ccyy	xxx.xx

NEXT SCREEN _____ PF5=DETL, PF6 = PREF, PF7=PG BACK, PF8=PG FORW

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Data displayed includes:

- **STATE ID** is the person's MEPD identifying number.
- **CASE #** is the person's MEPD case number and the person's last and first name.
- **CREDIT** is the dollar amount credited to the person's state identification number.
- **OWES** is the dollar amount the person owes under the state identification number.
- **WORKER** is the identifying number assigned to the income maintenance worker.
- **COUNTY** is the county number assigned to the income maintenance worker.
- **DATE** is the month and the year for the summary.
- **60M** is the field that shows the eligibility for MEPD.

  Valid active codes are:

  B Month has been blocked
  Y Month of MEPD eligibility ($0 premium or paid premium)
  P Month of potential MEPD eligibility (unpaid premium)

  Valid inactive codes are:

  N No MEPD activity.
  X Terminated months at conversion of initial MEPD system.
  M Month has reached maximum due date. Unable to pay dollar amount for the month.
  O Client became eligible for another coverage group for the month.
  R Retroactive entry. It takes two days after the date retroactive eligibility is entered on the RETR screen for the eligibility to show as "Y" or "P."
- **PREM AMT** is the current dollar amount for the premium for the month and year.
- **DUE DATE** is the due date that the premium is to be paid.
- **AMOUNT RECEIVED** is the dollar amount of the payment displayed.
- **AMOUNT APPLIED** (not on the screen) AMOUNT PAID is displayed.
- **DATE APPLIED** is the date premium payment is entered on the system.
- **REFUND AMOUNT** is the dollar amount of the refunds in the month and year shown.
- **NEXT SCREEN** is the field that you enter the one of the four-character names on the MEPD menu to go to another MEPD screen.

- **PF5=DETL** is the function key that moves you to the DETL screen.
- **PF6=PREF** is the function key that moves you to the PREF screen.
- **PF7=PG BACK** is the function key to scroll backward to SUMM screens.
- **PF8=PG FORW** is the function key to scroll forward to SUMM screens.
- A display of informational and error messages may appear at the bottom of the screen.
- ### is a three-digit program code used by the Division of Data Management.

DETL = MEPD Detail

The DETL screen shows detailed information for the STATE ID for the specified month and year. You can access DETL in the following ways:

- From the MEPD MENU, place an 'X' by DETL field and press the ENTER key,
- From any MEPD screen, type "DETL" in the NEXT SCREEN field and press the ENTER key.
- From the SUMM screen, place the cursor on a detail line, and press the PF5 key.

```
DETL                              IOWA DEPARTMENT OF HUMAN SERVICES      DATE:  99/99/99
                                              MEPD DETAIL                TIME:  99:99:99
STATE ID: xxxxxxxx                  MM/YY 99 99     CASE #:  xxxxxxxxxx  xxxxxxxxxxxxxxxxxxxx
                                                             MO BALANCE……:999999.99
                                                             INIT PREM………..:999.99
TRANS              TRANS          TRANS          B/U         CURR PREM……..: 999.99
TYPE               DATE           AMOUNT         x           MAX DUE DATE…: 99/99/9999
xxxxxxxxxx         99/99/9999     999999.00      x           NXT MTH PREM…: 9.99
xxxxxxxxxx         99/99/9999     999999.00      x           WORKER…..:  XXXX
xxxxxxxxxx         99/99/9999     999999.00      x           COUNTY……:  99
xxxxxxxxxx         99/99/9999     999999.00      x
xxxxxxxxxx         99/99/9999     999999.00      x
xxxxxxxxxx         99/99/9999     999999.00      x
xxxxxxxxxx         99/99/9999     999999.00      x
xxxxxxxxxx         99/99/9999     999999.00      x
xxxxxxxxxx         99/99/9999     999999.00      x
xxxxxxxxxx         99/99/9999     999999.00      x
xxxxxxxxxx         99/99/9999     999999.00      x

NEXT SCREEN   xxxx    PF5=SUMM, PF7=PG UP, PF8=PG DN, PF10-PRI  MNTH, PF11=NXT MNTH
                                                                                  820
```

Screen field descriptions:

- **STATE ID** is the person's MEPD identifying number.
- **MM/YY** is the month and year you request MEPD detail information.
- **CASE # NAME** is the recipient's MEPD case number and last and first name.
- **MO BALANCE** is the net dollar amount of the balance for the month and year listed.
- **INIT PREM** is the dollar amount of the original premium for the month and year.
- **CURR PREM** is the dollar amount of the current premium for the month and year.
- **MAX DUE DATE** is the last date that a payment can be made (grace period till end of the month due).
- **NXT MTH PREM** is the dollar amount of the premium for the next system month.
- **WORKER** is the unique identifying number assigned to the income maintenance worker.
- **COUNTY** is the county number assigned to the income maintenance worker.
- **TRANS TYPE** is the description for the type of transaction that takes place for the specified month and year. Valid types of transactions are:

FUTUR PREM	The premium amount will be processed in the MEPD system for the next system month.
DEMOGR CHG	A change processed in MEPD system is for name, case number, or worker number.
PREMIUM	MEPD has received the premium from the ABC system.
MEDID	The MEPD system has received an eligibility record from the Medicaid Eligibility system.
NW FUT CLT	The premium will be processed in the MEPD system for the next system month (effective date of initial eligibility is in the future).
RETRO	Eligibility for a month before the current system month, has been entered on the RETR screen and processed in the MEPD system.
MEPC CHG	A change has been entered on the MEPC screen (i.e., premium amount, income, poverty level, or a month was blocked or unblocked).

POTEN ELIG	MEPD has received the eligibility record from the Medicaid Eligibility system.
PYMT RECVD	The date Quality Assurance entered the payment into the MEPD system.
AMT APPLD	The amount of payment applied in the MEPD system.
OTH AID TP	Another active aid type has overplayed 60-M eligibility for this month.
ADJUSTMENT	An adjustment is being made to the premium amount through the MEPC screen.
MAX DUE DT	The last date payment can be applied to the specified month.
REFUND	A refund has been processed in the MEPD system.
STMT PRINT	A billing statement has been generated.
MEPD ROLL	Month end has occurred and rolled data to the next system month.

- **TRANS DATE** is the date the transaction occurred.
- **TRANS AMOUNT** is the dollar amount of the transaction for a given month and year.
- **B/U** is the field that indicates if the month is "blocked" or "unblocked." The codes are B for "blocked" or U for "unblocked."
- **NEXT SCREEN** is the option that you can enter the four-character names on the MEPD Menu to go to another MEPD screen.
- **PF5=DETL** is the function key that moves you to the SUMM screen.
- **PF7=PG BACK** is the function key to scroll backward to other DETL screens.
- **PF8=PG FORW** is the function key to scroll forward to other DETL screens.
- **PF10=PRI MONTH** is the function key to scroll to a prior month.
- **PF11=NEXT MONTH** is the function key to scroll to the next month.
- A display of both informational and error messages may appear at the bottom of the screen.
- ### is a three-digit program code used by Division of Data Management.

PREF = Unprocessed Payments/Refunds

The PREF screen is used to display in real time a payment or refund for the entered state identification number that has not been applied yet but is entered in the MEPD system.

Premium payments are not entered into the MEPD system until approximately 3:00 p.m. or later. When the payment or refund has updated in overnight processing, the information is no longer displayed on the PREF screen but will be displayed on the SUMM screen.

PREF can be accessed the following ways:

- From the MEPD menu by placing an 'X' by the PREF field and pressing the ENTER key.
- From any MEPD screen by typing PREF in the NEXT SCREEN field and pressing the ENTER key.
- From the SUMM screen by pressing the PF6 function key.

```
PREF                          IOWA DEPARTMENT OF HUMAN SERVICES
                                UNPROCESSED PAYMENTS/REFUNDS
STATE ID: xxxxxxxx

RCVD  DATE      PMT AMT     TYPE      CHECK NBR    NAME ON CHECK      METH
MM/DD/CCYY      XXXX.XX     XXXXX       XXXX         XXXX XXXX        XXXX
MM/DD/CCYY      XXXX.XX     XXXXX       XXXX         XXXX XXXX        XXXX

NEXT SCREEN        PF6=SUMM,   PF7=BACK,   PF8=FORW
```

Screen field descriptions:

- **STATE ID** is the person's MEPD identifying number.
- **RCVD DATE** is the date the payment/refund was entered.

- **PMT AMT** is the dollar amount of the payment entered.
- **TYPE** is the method of payment or refund. Valid entries are: CHECK, CASH, MO (money order), TC (travelers checks), REFND (refund).
- **CHECK NBR** is the number of the payment made by a check.
- **NAME ON CHECK** is the name of the person if payment is received by a check.
- **METHOD (METH)** is the field used to display if a refund is made and the codes used to display the method of the refund payment.
- **AREF** is the field used to show an automatic refund by the MEPD system.
- **RREF** is the field to show if it was a worker or a client requested refund.
- **NEXT SCREEN** is the option that you can use to enter the four-character screen names from the MEPD Menu to go to another MEPD screen.
- **PF6=SUMM** is the function key to move to the SUMM screen.
- **PF7=PG BACK** is the function key to scroll backward to view more payment/refund entries.
- **PF8=PG FORW** is the function key to scroll forward to view more payment/refund entries.
- A display of informational and error messages may appear at the bottom of the screen.
- ### is a three-digit program code used by the Division of Data Management.

RETR = Retro Screen

The RETR screen is really two screens in one, including:

- A block of information that is pulled from TD01 fields when the case has already been entered and processed on ABC; and
- The RETRO MONTH box, which is used to approve month-by-month retroactive eligibility for MEPD or to change entries that were previously made for a month.

The RETR screen is used to:

- Enter retroactive eligibility for MEPD only.
- Change past retroactive entries for MEPD when the entry for retroactive eligibility was made on or after June 1, 2002.
- Display past MEPD retroactive eligibility information when the entry for retroactive was made on or after June 1, 2002.

RETR can be accessed in the following ways:

- From the MEPD MENU by placing an 'X' by the RETR field and pressing the ENTER key.
- From any MEPD screen by typing RETR in the NEXT SCREEN field and pressing the ENTER key.

```
RETR                          IOWA DEPARTMENT OF HUMAN SERVICES     DATE:  99/99/99
                                        RETRO ELIGIBILIY            TIME:  99:99:99

STATE ID: xxxxxxxx                  RECIPIENT NAME (FML):  xxxxxxxx x xxxxxxxxxxxx
AID TYPE:  XXX            CASE NAME (FML)……..:  xxxxxxxx x xxxxxxxxxxxx
                          PAYEE NAME…… : xxx xxxxxxxxxxxxxxxxxxxxxxxx
BIRTH DATE……:99  99  9999   SEX: X          ========================
                                              |      RETRO MONTH       |
SSN……: 999  99  9999                         |                        |
INSURANCE……: 000 9                ETHNIC: X  | ELIG DATE……..: 99 9999 |
CASE NUMBER:  XXXXXXXXX                      | PREMIUM AMOUNT..:99999.99 |
ADDRESS:      XXXXXXXXXXXXXXXXXXX            | UNEARNED INCOME:99999.99 |
              XXXXXXXXXXXXXXXXXXX            | EARNED INCOME……:99999.99 |
CITY:         XXXXXXXXXXXXX                  | PREMIUM PCT POV..:999    |
STATE:        XX    ZIP:  99999 9999         | RESOURCES……..:      0.00 |
                                              | PF10-BACK PF11-FORWARD   |
RES COUNTY:   99                              ========================
EMPL HRS:     X
EMPL TYPE:    X
FAMILY SIZE:  99                  DO YOU WANT TO ENTER ANOTHER RET-
WORKER NUM.:  XXXX                RO MONTH FOR THIS STATE ID?  (Y/N)
WORKER CNTY:  99                  IF Y, ENTER NEW ELIG DATE AND PF3
                                  IF N, PRESS ENTER

NEXT SCREEN  XXXX       PF3=UPD, PF4=DELETE, PF1=MAIN MENU
                                                                      ###
```

Enter the state ID number and the eligibility date to view information or make entries. All fields must be completed for the screen to update. When using RETR to make retroactive entries, enter the state ID number on the upper left side of the screen and the eligibility date in the RETRO MONTH box and press ENTER. This ensures that further entries will be preserved.

Enter the information in the RETRO MONTH box separately for each month of retroactive eligibility that is being approved or changed. When entries are complete, press the PF3 key twice so entries will take.

Screen field descriptions:

- **STATE ID** is the person's MEPD identifying number.
- **RECIPIENT NAME (FML)** is the person's first, middle, and last name.
- **AID TYPE** is the medical aid type. The only valid type is 60-M.
- **CASE NAME (FML)** is the case name in first, middle, and last order.
- **PAYEE MODIFIER** is the field that modifies the payee name, e.g. FOR.
- **PAYEE NAME** is the name of the payee for the state ID number.
- **BIRTH DATE** is the person's date of birth.
- **SEX** is the person's gender.
- **SSN** is the person's social security number.
- **INSURANCE** is the person's insurance code. Only the last character is modifiable.
- **ETHNIC** is the person's ethnic code.
- **CASE NUMBER** is the person's MEPD case number.
- **ADDRESS LINE 1** is the first line of the person's mailing address.
- **ADDRESS LINE 2** is the second line of the person's mailing address.
- **CITY** is the mailing address city.
- **STATE** is the mailing address state.
- **ZIP** is the mailing address zip code and zip+4 digits.
- **RES COUNTY** is the number of the county where the person resides.

- **EMPL HOURS** is the number of hours the person is employed. Valid codes are:

  A Zero to 10 hours employment for month.
  B Above 10 hours through 80 hours of employment per month.
  C More than 80 hours of employment per month.

- **EMPL TYPE** is the type of employment of the person. Valid codes are:

  O Business outside the home.
  S Self-employment business.
  I Working for an individual.
  U Not employed.

- **FAMILY SIZE** is the number of people in the person's family.

- **WORKER NUM:** is the identifying number assigned to the income maintenance worker.

- **WORKER CNTY:** is the county number assigned to the income maintenance worker.

- **RETRO MONTH** box:

  - **ELIG DATE** is the actual retroactive month and year.
  - **PREMIUM AMOUNT** is the dollar amount for the premium for the retroactive month.
  - **UNEARNED INCOME** is the unearned income dollar amount for the person.
  - **EARNED INCOME** is the earned income dollar amount for the person.
  - **PREMIUM PCT POV** is the percent of poverty for the person.
  - **RESOURCES** is the resource amount for the person.
  - **PF10 BACK** is the function key to move to the previous month.
  - **PF11 FORWARD** is the function key to move to the next month.

- **DO YOU WANT TO ENTER ANOTHER RETRO MONTH FOR THIS STATE ID?** is the field where you indicate if you want to enter an additional month of retroactive coverage for the person. If so, enter the month and year and press the PF3 key. If not, press ENTER.

- **NEXT SCREEN** is the field you enter the four-character name on the MEPD menu to go to from another MEPD screen.

- **PF3=UPD** is the function key to add the record. Must be entered twice to record entry.

- **PF4=DELETE** is the function key to delete the record.

- **PF1=MAIN MENU** is the function key to go to the MEPD MAIN MENU.

- A display of informational and error messages may appear at the bottom of the screen.

- ### is a three-digit program code used by the Division of Data Management.

STMT = Billing Statement Screen

The STMT screen displays the current and previous statements. STMT can be accessed in the following ways:

- ♦ From the MEPD MENU, place an ‘X’ by the STMT field and press the ENTER key.
- ♦ From any MEPD screen, type “STMT” in the NEXT SCREEN field and press the ENTER key.

Enter the state identification number and the approximate billing date. If a billing date is not entered, the most recent statement will be displayed.

```
STMT                      IOWA DEPARTMENT OF HUMAN SERVICES        DATE:  99/99/99
                                BILLING STATEMENT                  TIME:  99:99:99
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXX            BILLING DATE: 99 99 99           CREATE STMT X
XXXXXXXXXXXXXXXXXXXXXXX            STATE ID  :    XXXXXXXX
XXXXXXXXXXXXXX XX   99999-9999     AMT DUE   :   +99999.99         REPRINT (CLNT)  X
                                   CREDIT AMT:    99999.99         REPRINT (WRKR) X
```

ELIG MONTH	FUT MO	PREMIUM AMOUNT	DUE DATE	PAYMENT RECEIVED	PAYMENT APPLIED	DATE APPLIED	REFUND AMOUNT
XXX 99	X	$999.99	99/99/9999	$999999.99	$999999.99	99/99/9999	$999999.99
XXX 99	X	$999.99	99/99/9999	$999999.99	$999999.99	99/99/9999	$999999.99
XXX 99	X	$999.99	99/99/9999	$999999.99	$999999.99	99/99/9999	$999999.99
XXX 99	X	$999.99	99/99/9999	$999999.99	$999999.99	99/99/9999	$999999.99
XXX 99	X	$999.99	99/99/9999	$999999.99	$999999.99	99/99/9999	$999999.99
XXX 99	X	$999.99	99/99/9999	$999999.99	$999999.99	99/99/9999	$999999.99
XXX 99	X	$999.99	99/99/9999	$999999.99	$999999.99	99/99/9999	$999999.99
XXX 99	X	$999.99	99/99/9999	$999999.99	$999999.99	99/99/9999	$999999.99
XXX 99	X	$999.99	99/99/9999	$999999.99	$999999.99	99/99/9999	$999999.99
XXX 99	X	$999.99	99/99/9999	$999999.99	$999999.99	99/99/9999	$999999.99
XXX 99	X	$999.99	99/99/9999	$999999.99	$999999.99	99/99/9999	$999999.99

```
NEXT SCREEN XXXX      PF3=PRINT,  PF7=PG UP, PF8=PG DN, PF10=PRI STMT,  PF11=NXT STMT
                                                                                ###
```

Screen field descriptions:

- ♦ **NAME** is the member name.
- ♦ **ADDRESS** is the first line of the mailing address.
- ♦ **BILLING DATE** is the date the bill is written.

- **CREATE STMT** is used to generate a new billing statement that has not been previously generated. Enter a 'Y' and press the PF3 key, then check the information that you entered and press the PF3 key again.

  Note: A screen message stating "STATEMENT WILL BE CREATED FOR THIS STATE ID" will appear when entries are successful. The new statement will show billing information as of the date you request the statement.

- **ADDRESS** is the second line of the mailing address.

- **STATE ID** is the member's state identification number.

- **CITY, STATE, ZIP** is the city, state, zip, and zip+4 of the mailing address.

- **AMT DUE** is the total dollar amount outstanding.

- **REPRINT (CLNT)** may be used to request a printed duplicate statement for the member by entering a 'Y' and pressing PF3 key twice. Successful entry results in the message "REPRINT SUCCESSFULLY INITIATED. REPRINTS PROCESS OVERNIGHT" at the bottom of the screen. **Note:** If the address is changed, the new address must be on the ABC system to have the duplicate statement go to the correct address.

- **CREDIT AMT** is the total dollar amount in the credit.

- **REPRINT (WRKR)** may be used to request a printed duplicate statement for the worker by entering a 'Y' and pressing PF3 key twice. Successful entry results in the message "REPRINT SUCCESSFULLY INITIATED. REPRINTS PROCESS OVERNIGHT" at the bottom of the screen.

- **ELIG MONTH** is the eligibility month and year.

- **FUT MO** indicates if the eligible month is a future month.

- **PREMIUM AMOUNT** is the premium dollar amount for that ELIG MONTH.

- **DUE DATE** is the date payment is due for that ELIG MONTH.

- **PAYMENT RECEIVED** is the dollar amount received during the ELIG MONTH.

- **PAYMENT APPLIED** is the dollar amount applied to premium for that ELIG MONTH.

- **DATE APPLIED** is the date the dollar amount was applied to premium for that ELIG MONTH.

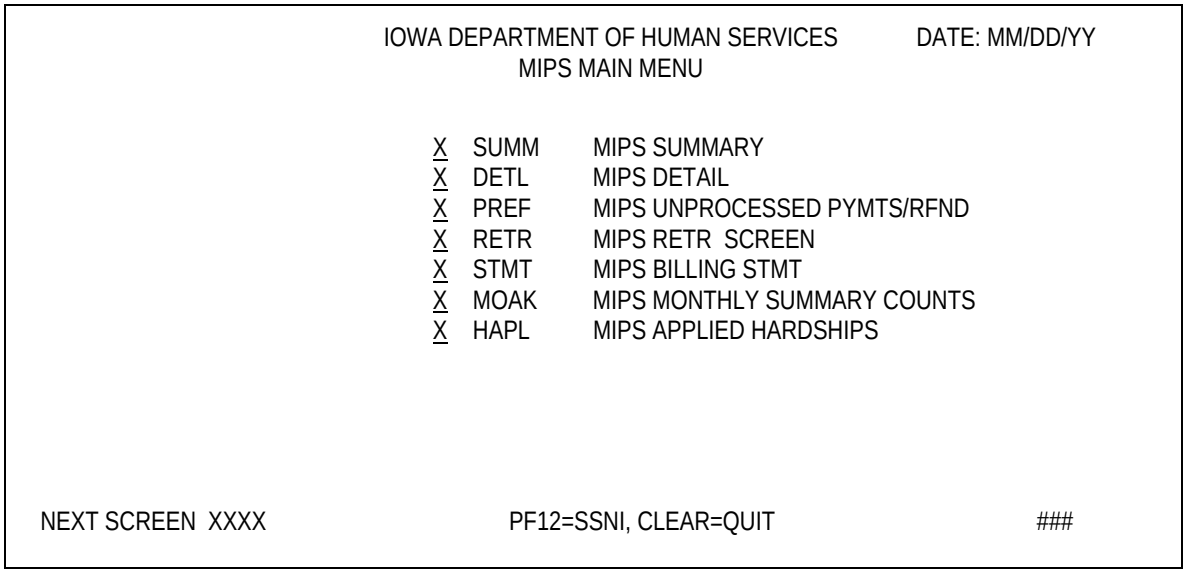
- **REFUND AMOUNT** is the total dollar amount of any refunds during that ELIG MONTH.
- **NEXT SCREEN** is the field you enter the four-letter name to go to another MEPD screen. Options are: SUMM, DETL, RETR.
- **PF3=PRINT** is the function key used to generate a duplicate billing statement.
- **PF7=PG UP** is the function key to scroll backward to view more eligibility months on a statement.
- **PF8=PG DN** is the function key to scroll forward to view more eligibility months on a statement.
- **PF10=PRI STMT** is the function key to scroll to prior billing statement (STMT) screen.
- **PF11=NEXT STMT** is the function key to scroll to the next billing statement (STMT) screen.
- A display of informational and error messages may appear at the bottom of the screen.
- ### is a three-digit program code used by the Division of Data Management.

MIPS BILLING SCREENS

The Medicaid IowaCare Premium System (MIPS) is a set of screens that are used to record premiums, billing statements, payments, and granting hardship claims made for each IowaCare member who is assessed a monthly premium payment. The following sections explain:

MIPS Main Menu Screen

The MIPS Main Menu shows a list of the available MIPS screens.



The MIPS Main Menu can be accessed the following ways:

- From a blank screen, enter MIPS.
- From the SSNI Selection Menu by pressing the PF11 key.
- From any of the MIPS screens by pressing the PF1 key.

To use the menu screen, place an 'X' in front of the screen you wish to view **or** enter a four-digit screen name of SUMM, DETL, PREF, STMT, MOAK, or HAPL in the NEXT SCREEN field and press the ENTER key.

Screen field descriptions:

- **SUMM** is the field to access the SUMM screen.
- **DETL** is the field to access the DETL screen.
- **PREF** is the field to access the PREF screen.
- **RETR** is the field to access the RETR screen.

- **STMT** is the field to access the STMT screen.
- **MOAK** is the field to access the MOAK screen.
- **HALP** is the field to access the HALP screen.
- **NEXT SCREEN** is the field to move you to another screen in the MIPS system.
- **PF12=SSNI** is the function key to transfer to the SSNI Selection Menu.
- **CLEAR=QUIT** is the key to move you out of the MIPS screen.

Note: Press the PF1 function key to return to the MIPS Main Menu from the other screens.

SUMM = MIPS Summary Screen

The SUMM screen shows a summary for each month of the premium amount, the amount applied, the hardship indicator, and the last activity date. The SUMM screen can be accessed the following ways:

- From the MIPS MENU by placing an 'X' by the SUMM field and pressing the ENTER key.
- From any MIPS screen by typing SUMM in the NEXT SCREEN field and pressing the ENTER key.
- From the DETL screen by pressing the PF5 key.
- From the PREF screen by pressing the PF6 key.

```
SUMM                    IOWA DEPARTMENT OF HUMAN SERVICES          DATE:  MM/DD/YY
                                MIPS SUMMARY                       TIME:  99:99:99
STATE ID:                       CASE #                  LAST NAME FIRST NAME
CREDIT:          OWES:          WORKER:    XXXX         CNTY:  XXX
STATUS:
                 PREM    PAYMENT   AMOUNT    AMOUNT    DATE      REFUND    HRDSH  MD    POSTMARK
DATE     ELG     AMT     DUE DTE   RCVD      APPLIED   APPLIED   AMOUNT    IN  RS  MO    DATE
mm/yy            xxx xx  mm/dd/yy  xxx.xx    xxx.xx    mm/dd/yy  xxx.xx

NEXT SCREEN_____ PF5=DETL,     PF6=PREF,     PF7=PG BACK,     PF8=PG FORW,     PF13=RSN CODES
                                                                                    ###
```

Data displayed includes:

- **STATE ID** is the member's MIPS identifying number.
- **CASE #** is the member's MIPS case number and the member's last and first name.
- **CREDIT** is the dollar amount that has not been applied to premium payments.
- **OWES** is the dollar amount the member owes under the state identification number.
- **WORKER** is the identifying number assigned to the income maintenance worker.
- **CNTY** is the county number assigned to the income maintenance worker.
- **STATUS** displays the status of the member's premium payments. Valid remarks are:

  PAST DUE BEFOR 10 DAYS: The IowaCare member did not pay the premium by the due date, but has **not** received a notice of cancellation because the date is before timely notice in the grace period month.

  PAST DUE AFT 10 DAYS: The IowaCare member has received a notice of cancellation due to failure to pay premiums or to ask timely for a hardship.

  NO PAST DUE MONTHS: The IowaCare member is up to date on premium payments.

- **DATE** is the month and the year for the summary.
- **ELG** is the field that shows the eligibility for MIPS (60-E or 60-P). Valid codes are:

  B Blocked; the month will not be billed, nor will money be applied to this month.
  C This month is blocked, but the ABC system has not sent an eligibility record for this month.
  D Eligibility record received; the member has died.
  E Mandatory month, but the ABC system has not sent an eligibility record and the TXIX system has received record that client has died. MIPS will stop billing.
  F Mandatory month, but the ABC system has not sent an eligibility record, and full Medicaid eligibility exists. MIPS will stop billing.
  N An "N" at month-end means no IowaCare activity.
  O Eligibility received, but full Medicaid eligibility exists. MIPS will stop billing.
  R Premium owed; no member eligibility.
  Y Month of IowaCare eligibility ($0 premium or paid premium).

- **PREM AMT** is the current dollar amount of the premium for that month and year.

- **PAYMENT DUE DTE** is the due date that the premium is to be paid.
- **AMOUNT RCVD** is the total dollar amount of the payment received during that system month.
- **AMOUNT APPLIED** is the amount applied to each month.
- **DATE APPLIED** is the date premium payment is entered on the system.
- **REFUND AMOUNT** is the dollar amount of the refunds in the month and year shown.
- **HRDSH IN** shows whether hardship was granted for the monthly premium. Codes are:

  Y Hardship granted for the month
  N No hardship for the month

- **HRDSH RS** displays codes that are used to make changes or corrections. You can access a list of these codes by pressing the SHIFT and PF1 keys together. Valid codes are:

  AE Agency error
  AP Appeal
  EX Exception to policy
  LT Hardship received too late
  OT Other
  PD Month already paid
  RA Reopen due to appeal
  RC Remove hardship correction
  RH Remove hardship
  TR Transfer of funds

- **MD MO** shows whether this is a mandatory month for premium payment. Codes are:

  Y Mandatory month
  N Nonmandatory month

- **POSTMARK DATE** displays the postmark for hardship requests received by Iowa Medical Enterprise (IME) **after** the due date.
- **NEXT SCREEN** allows entry of the one of the four-character names on the MIPS menu to go to another MIPS screen.
- **PF5=DETL** is the function key that moves you to the DETL screen.
- **PF6=PREF** is the function key that moves you to the PREF screen.
- **PF7=PG BACK** is the function key to scroll backward to SUMM screens.

- **PF8=PG FORW** is the function key to scroll forward to SUMM screens.
- **PF13=RSN CODES** is the function key used to display the valid hardship reason codes. (See HRDSH RS for a list of those codes.)
- A display of both informational and error messages may appear at the bottom of the screen.
- ### is a three-digit program code used by the Division of Data Management.

DETL = MIPS Detail

The DETL screen shows detailed information for the STATE ID for the specified month and year. You can access DETL in the following ways:

- From the MIPS MENU, place an 'X' by DETL field and press the ENTER key.
- From any MIPS SCREEN, type "DETL" in the NEXT SCREEN field and press the ENTER key.
- From the SUMM screen, place the cursor on the detail line for the month to be detailed, and press the PF5 key.

```
DETL                          IOWA DEPARTMENT OF HUMAN SERVICES        DATE:  MM/DD/YY
                                          MIPS-DETAIL                  TIME:  99:99:99
STATE ID: xxxxxxxx                MM/YY: 99 99   CASE #:  xxxxxxxxxx  LAST NAME FIRST NAME
                                                                      MO BALANCE: 999999.99
                                                                      INIT PREM.....: 999.99
TRANS        TRANS       TRANS        B/U   HRDSHP      MAND         CURR PREM..: 999.99
TYPE         DATE        AMOUNT             IND         MO. IND      DUE DATE.....: 99/99/9999

xxxxxxxxxx   99/99/9999  999999.00    x                               WORKER.....:  XXXX
xxxxxxxxxx   99/99/9999  999999.00    x                               COUNTY.....:  99
xxxxxxxxxx   99/99/9999  999999.00    x
xxxxxxxxxx   99/99/9999  999999.00    x
xxxxxxxxxx   99/99/9999  999999.00    x
xxxxxxxxxx   99/99/9999  999999.00    x
xxxxxxxxxx   99/99/9999  999999.00    x
xxxxxxxxxx   99/99/9999  999999.00    x
xxxxxxxxxx   99/99/9999  999999.00    x
xxxxxxxxxx   99/99/9999  999999.00    x
xxxxxxxxxx   99/99/9999  999999.00    x
xxxxxxxxxx   99/99/9999  999999.00    x

NEXT SCREEN  xxxx   PF5=SUMM, PF7=PG UP, PF8=PG DN, PF10-PRI  MNTH, PF11=NXT MNTH
                                                                                ###
```

Screen field descriptions:

- **STATE ID** is the member's MIPS identifying number.
- **MM/YY** is the month and year you request MIPS detail information.
- **CASE # NAME** is the member's MIPS case number and last and first name.
- **MO BALANCE** is the net dollar amount of the balance for the month and year listed.
- **INIT PREM** is the dollar amount of the original premium for the month and year.
- **CURR PREM** is the dollar amount of the current premium for the month and year.
- **DUE DATE** is the payment due date.
- **WORKER** is the unique identifying number assigned to the income maintenance worker.
- **COUNTY** is the county number assigned to the income maintenance worker.
- **TRANS TYPE** is the description for the type of transaction that is taking place for the specified month and year. Valid types of transactions are:
  - **FUTUR PREM:** The premium amount will be processed in the MIPS system for the next system month.
  - **DEMOGR CHG:** A change in name, case number, or worker number is processed in MIPS system.
  - **PREMIUM:** MIPS has received the premium amount from the ABC system.
  - **NW FUT CLT:** The premium will be processed in the MIPS system for the next system month. (The effective date of initial eligibility is in the future.)
  - **RETRO:** Eligibility for a month before the current system month has been entered on the RETR screen and processed in the MIPS system.
  - **MIPC CHG:** A change in premium amount, income, poverty level, or hardship has been entered on the MIPC screen.
  - **ACTIV ELIG:** MIPS has received an active eligibility record from ABC for a month.
  - **MAN NOELIG:** A mandatory month is being billed for the premium amount, but no eligibility record has been received from ABC system.
  - **PYMT RECVD:** The date the payment is entered into the MIPS system.

- **AMT APPLD:** The amount of payment applied in the MIPS system.
- **AUTO CLOSE:** Date the MIPS billing system sent notification to the ABC system verifying no payment has been made for a specific due date.
- **LT PMT RCV:** Notification (WIFS) to IM worker that a late payment has been received.
- **REFUND:** A refund has been processed in the MIPS system.
- **STMT PRINT:** A billing statement has been generated.
- **REMIND NTC:** The date an 'IowaCare Premium Notice Reminder' was sent to the client.
- **MIPS ROLL:** Month end has occurred and rolled data to the next system month.

♦ **TRANS DATE** is the date the transaction occurred.

♦ **TRANS AMOUNT** is the dollar amount of the transaction for a given month and year.

♦ **B/U** Reserved for future use.

♦ **HRDSHP IND** is the field that shows if hardship was granted for the monthly premium. Valid codes are:

Y	Hardship granted for the month
Blank	No hardship for the month

♦ **MAND MO. IND** is the field that shows if this is a mandatory month. Valid codes are:

Y	Mandatory month
N	Nonmandatory month

♦ **NEXT SCREEN** is the option that you can enter the four-character names on the MIPS Menu to go to another MIPS screen.

♦ **PF5=SUMM** is the function key that moves you to the SUMM screen.

♦ **PF7=PG UP** is the function key to scroll backward to other DETL screens.

♦ **PF8=PG DN** is the function key to scroll forward to other DETL screens.

♦ **PF10=PRI MNTH** is the function key to scroll to a prior month.

♦ **PF11=NEXT MNTH** is the function key to scroll to the next month.

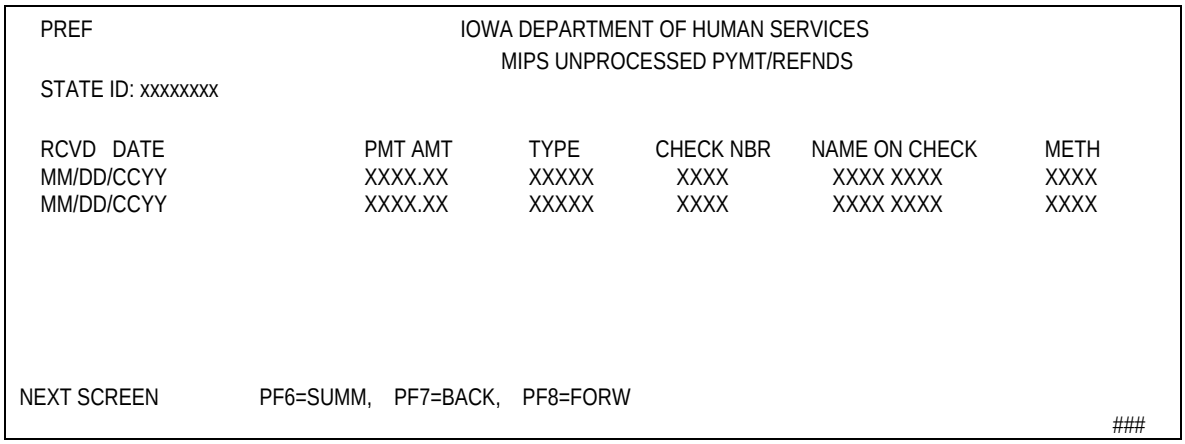
A display of informational or error messages may appear at the bottom of the screen. ### is a three-digit program code used by Division of Data Management.

PREF = Unprocessed Payments/Refunds

Premium payments are entered into the MIPS system daily when received. The PREF screen displays in real time for the entered state identification number a payment or refund that is entered in the MIPS system but has not been processed yet. When the payment or refund has updated in overnight processing, the information is no longer displayed on the PREF screen but is instead displayed on the SUMM screen.

The PREF screen can be accessed in the following ways:

- From the MIPS menu by placing an 'X' by the PREF field and pressing the ENTER key.
- From any of the MIPS screens by typing PREF in the NEXT SCREEN field and pressing the ENTER key.
- From the SUMM screen by pressing the PF6 function key.



```
PREF                          IOWA DEPARTMENT OF HUMAN SERVICES
                                  MIPS UNPROCESSED PYMT/REFNDS
STATE ID: xxxxxxxx

RCVD  DATE          PMT AMT     TYPE      CHECK NBR    NAME ON CHECK      METH
MM/DD/CCYY          XXXX.XX     XXXXX       XXXX         XXXX XXXX        XXXX
MM/DD/CCYY          XXXX.XX     XXXXX       XXXX         XXXX XXXX        XXXX




NEXT SCREEN        PF6=SUMM,   PF7=BACK,   PF8=FORW
                                                                            ###
```

Screen field descriptions:

- **STATE ID** is the member's MIPS identifying number.
- **RCVD DATE** is the date the payment or refund was entered.
- **PMT AMT** is the dollar amount of the payment entered.

- **TYPE** is the method of payment or refund. Valid entries are: CHECK, CASH, MO (money order), TC (travelers checks).
- **CHECK NBR** is the number of the check or money order.
- **NAME ON CHECK** is the name of the person given on the check, money order, or receipt for cash.
- **METHOD (METH)** Reserved for future use.
- **NEXT SCREEN** allows entry of a four-character screen name from the MIPS Menu to go to another MIPS screen.
- **PF6=SUMM** is the function key to move to the SUMM screen.
- **PF7=BACK** is the function key to scroll backward to view more payment or refund entries.
- **PF8=FORW** is the function key to scroll forward to view more payment or refund entries.

A display of informational or error messages may appear at the bottom of the screen. ### is a three-digit program code used by the Division of Data Management.

RETR = Retro Screen

The RETR screen is actually two screens in one.

- A block of information that is pulled from the ABC system's TD01 screen fields when the case has already been entered and processed on ABC; and
- The RETRO MONTH box, which is used to approve month-by-month retroactive eligibility for MIPS or to change entries previously made for a month.

The RETR screen is used to:

- Enter retroactive eligibility for IowaCare premiums only.
- Change past retroactive MIPS entries when the entry for retroactive eligibility was made on or after July 1, 2005.
- Display past MIPS retroactive eligibility information when the entry for retroactive was made on or after July 1, 2005.

RETR can be accessed in the following ways:

- From the MIPS MENU by placing an 'X' by the RETR field and pressing the ENTER key.
- From any MIPS screen by typing RETR in the NEXT SCREEN field and pressing the ENTER key.

```
RETR                                IOWA DEPARTMENT OF HUMAN SERVICES      DATE:  99/99/99
                                    IOWACARE RETRO ELIGIBILITY             TIME:  99:99:99

STATE ID: xxxxxxxx                  RECIPIENT NAME (FML):  xxxxxxxx x xxxxxxxxxxxx
AID TYPE: XXX                       CASE NAME (FML)……..:  xxxxxxxx x xxxxxxxxxxxx
FUND CODE: X                        PAYEE NAME…… : xxx xxxxxxxxxxxxxxxxxxxxxxxx
BIRTH DATE……..:99  99  9999  SEX: X
SSN……..: 999  99  9999                          ┌──────────────────────┐
INSURANCE……: 000 9                  ETHNIC: X    │      RETRO MONTH     │
CASE NUMBER:  XXXXXXXXX        PERSON NUMBER: XX   │                      │
ADDRESS:      XXXXXXXXXXXXXXXXXXXX               │ ELIG DATE……..: 99 9999 │
              XXXXXXXXXXXXXXXXXXXX               │ PREMIUM AMOUNT..:99999.99 │
CITY:  XXXXXXXXXXXXX                             │ UNEARNED INCOME:99999.99 │
STATE:         XX   ZIP:  99999 9999             │ EARNED INCOME……:99999.99 │
                                                 │                      │
RES COUNTY:    99                                │ PF10-BACK PF11-FORWARD │
                                                 │                      │
                                                 └──────────────────────┘
                                    DO YOU WANT TO ENTER ANOTHER RET-
WORKER NUM.:  XXXX                  RO MONTH FOR THIS STATE ID?  (Y/N)
WORKER CNTY:  99                    IF Y, ENTER NEW ELIG DATE AND PF3
                                    IF N, PRESS ENTER

NEXT SCREEN  XXXX          PF3=UPD, PF4=DELETE, PF1=MAIN MENU
                                                                          ###
```

Enter the state ID number and the ELIG DATE to view information or make entries. All fields must be completed for the screen to update. When using RETR to make retroactive entries, complete the state ID number on the upper left side of the screen and the eligibility date in the RETRO MONTH box and press the ENTER key. This ensures that further entries will be preserved.

Enter the information in the RETRO MONTH box separately for each month of retroactive eligibility that is being approved or changed. When entries are complete, press the PF3 key twice so entries will take.

Note: When a retroactive month needs to be added to an IowaCare case after the initial approval entries are made in the ABC system, the eligibility months will not be added to the MIPS Billing system unless the entries are made on the MIPS RETR screen.

So, even when months of eligibility have been added using form 470-0397, *Request for Special Update*, RETR screen entries are needed to add months for premiums to be billed. Note that months added on the RETR screen will also update eligibility on SSNI. If SSNI already shows IowaCare eligibility, you may add the months on RETR for billing purposes.

Screen field descriptions:

- **STATE ID** is the member's MIPS identifying number.
- **RECIPIENT NAME (FML)** is the member's name in first, middle, and last name order.
- **AID TYPE** is the medical aid type. Valid types are 60-E and 60-P.
- **CASE NAME** is the case name in first, middle, and last name order.
- **FUND CODE** is the member's fund code.
- **PAYEE MODIFIER** is the field that modifies the payee name, e.g. FOR.
- **PAYEE NAME** is the name of the payee for the state ID number.
- **BIRTH DATE** is the member's date of birth.
- **SEX** is the member's gender.
- **SSN** is the member's social security number.
- **INSURANCE** is the member's insurance code. Only the last character is modifiable.
- **ETHNIC** is the member's ethnic code.
- **CASE NUMBER** is the member's most recent IowaCare case number.
- **ADDRESS LINE 1** is the first line of the member's mailing address.
- **ADDRESS LINE 2** is the second line of the member's mailing address.
- **CITY** is the mailing address city.
- **STATE** is the mailing address state.
- **ZIP** is the mailing address zip code and zip+4 digits.
- **RES COUNTY** is the county number where the person resides.
- **WORKER NUM** is the identifying number assigned to the income maintenance worker.

- **WORKER CNTY** is the county number assigned to the income maintenance worker.
- **RETRO MONTH** box:
  - **ELIG DATE** is the actual retroactive month and year.
  - **PREMIUM AMOUNT** is the dollar amount for the premium for the retroactive month.
  - **UNEARNED INCOME** is the unearned income dollar amount for the person.
  - **EARNED INCOME** is the earned income dollar amount for the member.
  - **PF10 BACK** is the function key to move to the previous month.
  - **PF11 FORWARD** is the function key to move to the next month.
- **DO YOU WANT TO ENTER ANOTHER RETRO MONTH FOR THIS STATE ID?** allows entry to indicate if you want to enter an additional retroactive month of coverage for the member. If so, enter the month and year and press PF3. If not, press ENTER.
- **NEXT SCREEN** allows entry of a four-character name on the MIPS menu to go to another MIPS screen.
- **PF3=UPD** is the function key to add the record. Must be entered twice to record entry.
- **PF4=DELETE** is the function key to delete the record.
- **PF1=MAIN MENU** is the function key to go to the MIPS MAIN MENU.

A display of informational or error messages may appear at the bottom of the screen. ### is a three-digit program code used by the Division of Data Management.

STMT = Billing Statement Screen

The STMT screen displays the current and previous statements. STMT can be accessed in the following ways:

- From the MIPS MENU, place an 'X' by the STMT field and press the ENTER key
- From any MIPS screen, type "STMT" in the NEXT SCREEN field and press the ENTER key.

Enter the state identification number and the approximate billing date. If a billing date is not entered, the most recent statement will be displayed.

```
STMT                                IOWA DEPARTMENT OF HUMAN SERVICES        DATE:  MM/DD/YY
                                          BILLING STATEMENT                  TIME:  99:99:99
XXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXX                  BILLING DATE:    99 99 99              CREATE STMT X
XXXXXXXXXXXXXXXXXXXXXXX                  STATE ID  :      XXXXXXXX
XXXXXXXXXXXXXXX XX   99999-9999          AMT DUE  :      +99999.99             REPRINT (CLNT) X
                                         CREDIT AMT:      99999.99             REPRINT (WRKR) X
ELIG        PREMIUM      DUE          PAYMENT        PAYMENT      DATE         REFUND
MONTH       AMOUNT       DATE         RECEIVED       APPLIED      APPLIED      AMOUNT
XXX  99     $999.99      99/99/9999   $999999.99     $999999.99   99/99/9999   $999999.99
XXX  99     $999.99      99/99/9999   $999999.99     $999999.99   99/99/9999   $999999.99
XXX  99     $999.99      99/99/9999   $999999.99     $999999.99   99/99/9999   $999999.99
XXX  99     $999.99      99/99/9999   $999999.99     $999999.99   99/99/9999   $999999.99
XXX  99     $999.99      99/99/9999   $999999.99     $999999.99   99/99/9999   $999999.99
XXX  99     $999.99      99/99/9999   $999999.99     $999999.99   99/99/9999   $999999.99
XXX  99     $999.99      99/99/9999   $999999.99     $999999.99   99/99/9999   $999999.99
XXX  99     $999.99      99/99/9999   $999999.99     $999999.99   99/99/9999   $999999.99
XXX  99     $999.99      99/99/9999   $999999.99     $999999.99   99/99/9999   $999999.99
XXX  99     $999.99      99/99/9999   $999999.99     $999999.99   99/99/9999   $999999.99
XXX  99     $999.99      99/99/9999   $999999.99     $999999.99   99/99/9999   $999999.99

NEXT SCREEN XXXX      PF3=PRINT,  PF7=PG UP, PF8=PG DN, PF10=PRI STMT,  PF11=NXT STMT
                                                                                   ###
```

Screen field descriptions are as follows:

- **NAME** is the member name.
- **ADDRESS** is the first line of the mailing address.
- **BILLING DATE** is the date the bill is written.
- **CREATE STMT** is used to generate a new billing statement that has not been previously generated. Enter a 'Y' and press the PF3 key; then check the information that you entered and press the PF3 key again. **Note:** A screen message stating "STATEMENT WILL BE CREATED FOR THIS STATE ID" will appear when successfully entered. The new statement will show billing information as of the date you request the statement.
- **ADDRESS** is the second line of the mailing address.
- **STATE ID** is the member state identification number.
- **CITY, STATE, ZIP** is the city, state, zip, and zip+4 of the mailing address.
- **AMT DUE** is the total dollar amount outstanding.

- **REPRINT (CLNT)** may be used to request a printed duplicate statement for the member by entering an 'Y' and pressing PF3 key twice. Successful entry results in the message "REPRINT SUCCESSFULLY INITIATED. REPRINTS PROCESS OVERNIGHT" at the bottom of the screen. **Note:** If the address is changed, the new address must be on the ABC system to have the duplicate statement for the member go to the correct address.
- **CREDIT AMT** is the total dollar amount that has not been applied to premium payments.
- **REPRINT (WRKR)** may be used to request a printed duplicate statement for the worker by entering an 'Y' and pressing PF3 key twice. Successful entry results in the message "REPRINT SUCCESSFULLY INITIATED. REPRINTS PROCESS OVERNIGHT" at the bottom of the screen.
- **ELIG MONTH** is the eligibility month and year.
- **PREMIUM AMOUNT** is the premium dollar amount for that ELIG MONTH.
- **DUE DATE** is the date payment is due for that ELIG MONTH.
- **PAYMENT RECEIVED** is the dollar amount received during the ELIG MONTH.
- **PAYMENT APPLIED** is the dollar amount applied to premium for that ELIG MONTH.
- **DATE APPLIED** is the date the payment was applied to premium for that ELIG MONTH.
- **REFUND AMOUNT** is the total amount of any refunds issued during that ELIG MONTH.
- **NEXT SCREEN** allows entry of a four-character name on the MIPS Menu to go to another MIPS screen.
- **PF3=PRINT** is the function key used to generate a duplicate billing statement.
- **PF7=PG BACK** is the function key to scroll backward to view more eligibility months on a statement.
- **PF8=PG FORW** is the function key to scroll forward to view more eligibility months on a statement.
- **PF10=PRI STMT** is the function key to scroll to prior billing statement screens (STMT).
- **PF11=NEXT STMT** is the function key to scroll to next billing statement screens (STMT).

A display of both informational and error messages may appear at the bottom of the screen. ### is a three-digit program code used by the Division of Data Management.

MOAK = Monthly Summary Counts Screen

The MOAK screen displays various summary counts for the Iowa Care program. This screen is for review by policy personnel. MOAK can be accessed in the following ways:

- From the MIPS MENU, place an 'X' by the MOAK field and press the ENTER key
- From any MIPS screen, type "MOAK" in the NEXT SCREEN field and press the ENTER key.

The system automatically brings up the current system month information.

```
MOAK                    DEPARTMENT OF HUMAN SERVICES
                        IOWACARE MONTHLY SUMMARY COUNTS
 MOAK MM/YY: MM YY
                          AMOUNTS COUNTS                              COUNTS
 ONGOING BILLED.:     XXX,XXX.XX XX,XXX   CURRENT ACTIVE CLIENTS..:  XX,XXX
 DAILY BILLED...:      XX,XXX.XX  X,XXX
                                           PAST DUE ADDED.........:     XXX
 PAYMENTS.......:      XX,XXX.XX  X,XXX   STOP BILLING............:     XXX
 ELEC PAYMENTS..:      XX,XXX.XX  X,XXX
 MANUAL PAYMENTS:      XX,XXX.XX    XXX   BILL STMT PRINT.........:   X,XXX
 OFFSITE PAYMNTS:       X,XXX.XX    XXX   BILL STMT CLIENT REPRINT:      XX
 CREDITS APPLIED:      XX,XXX.XX  X,XXX   BILL STMT WORKER REPRINT:       X

 REFUNDS........:         XXX.XX      X   REMINDER NOTICE STMTS...:   X,XXX
                                           OTHER MAILERS...........:       X
 HARDSHIPS DCLRD:      XX,XXX.XX  X,XXX
 HARDSHIPS ACCPT:      XX,XXX.XX  X,XXX   HARDSHIP OVERRIDES......:       X
 HARDSHIPS RJCTD:       X,XXX.XX     XX   HARDSHIPS REMOVED.......:       X

 MAND WITH ELIG.:      XX,XXX.XX  X,XXX   INACTIVE CLIENTS.........:  XX,XXX
 MAND W/O ELIG..:       X,XXX.XX    XXX   CURR OFFSITE RECEIPT NBR: XXXXXXX
                                           CURR OFFSITE DEPOSIT DTE: MM DD CCYY
 NEXT SCREEN             PF10=PRI MNTH     PF11=NXT MNTH                  ###
```

Screen field descriptions:

- **MOAK MM/YY** is the month and year of the summary counts being viewed.
- **ONGOING BILLED** is the total amount billed at the beginning of a system month.
- **DAILY BILLED** is the total amount of premiums billed for the current system month, during current system month, as cases are added to the MIPS system.
- **PAYMENTS AMOUNTS** is the total amount of payments received **in** a system month. One payment may be applied to multiple months.

- **PAYMENTS COUNTS** is the total number of payments processed in a month.
- **ELEC PAYMENTS AMOUNTS** is the total amount of electronic payments processed in a month.
- **ELEC PAYMENTS COUNTS** is the total number of electronic payments processed in a month.
- **MANUAL PAYMENTS AMOUNTS** is the total amount of manual payments entered into the MIPS system in a month.
- **MANUAL PAYMENTS COUNTS** is the total number of manual payments entered into the MIPS system in a month.
- **OFFSITE PAYMNTS AMOUNTS** is the total amount of offsite payments processed in a month.
- **OFFSITE PAYMNTS COUNTS** is the total number of offsite payments processed in a month.
- **CREDITS APPLIED AMOUNTS** is the total sum of credits applied **in** a system month.
- **CREDITS APPLIED COUNTS** is the total number of credits applied **in** a system month.
- **REFUNDS AMOUNTS** is the total sum of refunds issued **in** a system month.
- **REFUNDS COUNTS** is the total number of refunds applied **in** a system month.
- **HARDSHIPS DCLRD AMOUNTS** is the total value of months that a hardship was entered into the MIPS system, in a month.
- **HARDSHIPS DCLRD COUNTS** is the total number of hardships declared in a month.
- **HARDSHIPS ACCPT AMOUNTS** is the total value of months that have been granted hardship.
- **HARDSHIPS ACCPT COUNTS** is the total number of months that have been granted hardship.
- **HARDSHIPS RJCTD AMOUNTS** is the total value of hardships not granted in a month.
- **HARDSHIPS RJCTD COUNTS** is the total number of hardships **not** granted for a month, for whatever reason (i.e. too late, premium = $0, already paid, etc.)
- **MAND WITH ELIG AMOUNTS** is the total amount of premiums for mandatory months with eligibility from ABC in a month.

- **MAND WITH ELIG COUNTS** is the total number of mandatory months with an eligibility record from ABC in the month.
- **MAND W/O ELIG AMOUNTS** is the total amount of premiums billed for mandatory months that have no eligibility record from ABC in the month.
- **MAND W/O ELIG COUNTS** is the total number of mandatory months billed that have no eligibility record from ABC in the month.
- **CURRENT ACTIVE CLIENTS** is the total number of current active Iowa Care members on the MIPS system.
- **PAST DUE ADDED** is the total number of members whose premiums are past due.
- **STOP BILLING** is the total number of Iowa Care members to whom the MIPS system has sent a final billing statement.
- **BILL STMT PRINT** is the total number of billing statements mailed to Iowa Care members in the month.
- **BILL STMT CLIENT REPRINT** is the total number of reprinted billing statements mailed to IowaCare members in the month.
- **BILL STMT WORKER REPRINT** is the total number of reprints of billing statements generated to go to IM workers in the local office. These are not mailed.
- **REMINDER NOTICE STMTS** is the total number of IowaCare Premium Notice Reminder forms (the "friendly reminder" letter) sent to the Iowa Care members in a month.
- **OTHER MAILERS** is the count for any 'other' mailings that are generated for IowaCare members. Currently, we have no other mailings.
- **HARDSHIP OVERRIDES** are number of exceptions to policy granted in a month on cases where policy dictates the case was not eligible for hardship.
- **HARDSHIPS REMOVED** are the corrections showing the total count of hardships that are removed in a month.
- **INACTIVE CLIENTS** is the total number of inactive Iowa Care members on the MIPS system when rolling into a new month.
- **CURR OFFSITE RECEIPT NBR** is the current receipt number for payments entered at Broadlawns Medical Center for Iowa Care members.

- **CURR OFFSITE DEPOSIT DTE** is the current deposit date for Broadlawns payments to be deposited into the bank.
- **NEXT SCREEN** allows entry of a four-character name on the MIPS menu to go to another MIPS screen.
- **PF10=PRI MNTH** is the function key to scroll to a prior month's summary counts screen.
- **PF11=NXT MNTH** is the function key to scroll to the next month's summary counts screen.
- ### is a three-digit program code used by the Division of Data Management.

HAPL = MIPS Applied Hardships

The HAPL screen shows the 'breakdown' of partial payment hardships for eligible. HAPL can be accessed in the following ways:

- From the MIPS MENU, place an 'X' by the HAPL field and press the ENTER key
- From any MIPS screen, type "HAPL" in the NEXT SCREEN field and press the ENTER key.

```
HAPL                      DEPARTMENT OF HUMAN SERVICES
                              MIPS APPLIED HARDSHIPS
 STATE ID :

 ELIG DATE........:
 APPLIED DATE.....:
 ORIG ENTERED DATE:

 PREMIUM AMT......:
 PARTIAL PREM PAID:
 PREM AMT FORGIVEN:

 TSO ID...........:

 HARDSHIP ENTERED
    HARDSHIP IND.....:
    HARDSHIP RSN CODE:
    POSTMARKED DATE..:

 OVERRIDE SW......:


 NEXT SCREEN XXXX      PF10=PRI HAPL, PF11=NXT HAPL, PF13=RSN CODES
                                                  ###
```

Screen field descriptions:

- **STATE ID** is the member's state id number.
- **ELIG DATE** is the month of eligibility.
- **APPLIED DATE** is the date the hardship was applied to the month.
- **ORIG ENTERED DATE** is the date hardship was entered into the system.
- **PREMIUM AMT** is the billed premium amount.
- **PARTIAL PREM PAID** is the amount of partial payment applied to the month.
- **PREM AMT FORGIVEN** is the amount of premium forgiven (the amount of the premium the Iowa Care member is not responsible to pay, as hardship was applied; this could be the full amount of the premium or a partial amount).
- **TSO ID** is not applicable.
- **HARDSHIP ENTERED HARDSHIP IND** is the hardship indicator. Valid codes are:

  H Hardship entered
  R Hardship removed

- **HARDSHIP ENTERED HARDSHIP RSN CODE** is the hardship reason code. Valid codes are:

  AE Agency error
  AP Appeal
  EX Exception to policy
  LT Hardship received too late
  OT Other
  PD Month already paid
  RA Reopened due to appeal
  RC Remove hardship (correction)
  RH Remove hardship
  TR Transfer of funds

- **HARDSHIP ENTERED POSTMARKED DATE** is the postmark date on the billing statement which the member claimed hardship.
- **OVERRIDE SW** indicates with a 'Y' if an override was performed for this date of eligibility. An override can only be completed by Central Office staff and can either allow or remove a hardship.

- **NEXT SCREEN** allows entry of a four-character name on the MIPS menu to go to another MIPS screen.
- **PF10=PRI HAPL** is the function key to scroll to a prior month's hardship screen.
- **PF11=NXT HAPL** is the function key to scroll to the next month's hardship screen.
- **PF13=RSN CODES (SHIFT + PF1)** is the function key used to display the valid Hardship Reason codes. See HARDSHIP ENTERED HARDSHIP RSN CODE for a list of the codes.
- ### is a three-digit program code used by the Division of Data Management.

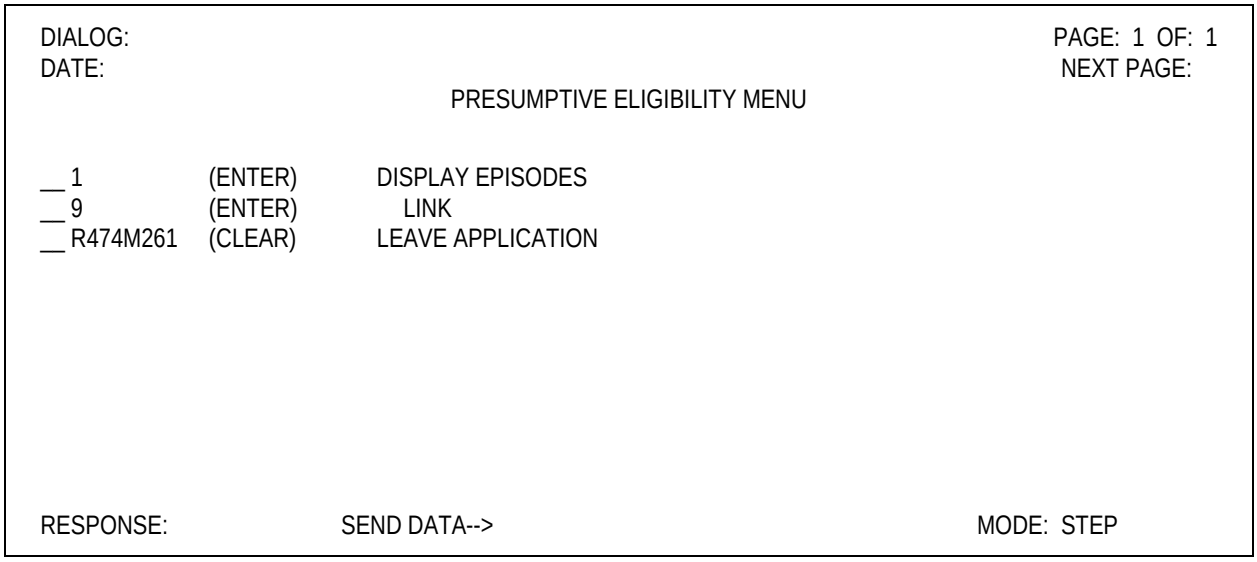
PRSM = PRESUMPTIVE MEDICAID ELIGIBILITY

The Presumptive Medicaid Eligibility program allows certain providers to:

- Qualify pregnant women for prenatal medical treatment, excluding inpatient hospital services and services for birth and delivery, or
- Qualify women with breast or cervical cancer for full Medicaid services (not just services related to cancer treatment).

Unless the recipient applies for Medicaid, the initial eligibility period ends the last day of the month following the month of the presumptive determination. If the recipient files a formal Medicaid application in the initial period of presumptive eligibility, coverage is extended until an eligibility determination is made on the application.

PRSM displays demographic information and dates of eligibility for recipients of this program as determined by qualified providers. The menu is shown below.



To display or view the presumptive Medicaid eligibility information, enter an 'X' (or any character) beside selection 1 and press the ENTER key. The PRSM screen (following) returns empty with a message that prompts for a valid state ID. Type in the client's state ID and press the ENTER key. The following screen is returned:

```
STATE ID 0000000x          RECIPIENT NAME LAST  xxxxxxxxxxxxx      LAST UPDATE 000000
                                          FIRST  xxxxxxxx MI x
SOCIAL SECURITY 000000000                 ADDRESS xxxxxxxxxxxxxxxxxxxxx
                                                  xxxxxxxxxxxxxxxxxxxxx
BIRTHDATE mm dd yyyy                              xxxxxxxxxxxxxxx 000000000

CO     WORKER     SEX     ETHNIC     HANDICAP
00       0000       F       0          0000

                                                                          DECISION
TYPE   BEGIN DATE     END DATE     COUNTY   INSURANCE     PROVIDER   CASE        STATUS     REASON
 X       mm dd yy      00 00 00      00        0000          000000   XXXXXX XXXX

                                                                  PF1-MAIN MENU
```

This screen contains the presumptive Medicaid eligibility information concerning a client that was entered when a qualified provider determined presumptive eligibility. The creation or addition of presumptive eligibility records or episodes is restricted to Quality Assurance staff of the Division of Data Management.

The actual episode information (beginning and ending dates, county, etc.) is displayed in chronological order, with the most recent or current episode at the TOP of the list.

- **CO** is the county of the worker, if there is a case for the woman on the ABC system.
- **WORKER** is the worker number of the caseworker, if there is a case for the woman on ABC.
- **SEX** is always "F" for female.
- **ETHNIC** is the ethnic code for the woman.
- **HANDICAP** is the handicap code for the woman.

- **TYPE** is the presumptive code. Valid codes are:

  P Pregnant
  T Treatment
  W Worker determined Medicaid eligible

- **BEGIN DATE** is the date presumptive eligibility begins. This is usually the date that the presumptive application was taken.
- **END DATE** is the date of termination for presumptive eligibility.
- **COUNTY** is the client's county of residence.
- **INSURANCE** is the health coverage code for the woman.
- **PROVIDER** is the vendor number of the provider that made the presumptive eligibility determination.
- **CASE** is the case number assigned to the person that has a TYPE code of "W."
- **STATUS** represents the status of a Medicaid application recorded on the ABC system. If no Medicaid application has been pended, approved, or denied on ABC, an "E" appears in this field. Codes are as follows:

E	Eligible under presumptive Medicaid eligibility
A, B, or C	Active
D	Pending
M or N	Denied

- **DECISION REASON** is the notice reason from the ABC system for the Medicaid denial or approval for qualified pregnant women.

SSBI = BUY-IN SYSTEM

The SSBI system displays Medicare Part A and B buy-in information and history.

"Buy-in" is the payment of Medicare Part A and B premiums by the state for Medicaid-eligible recipients. Data transmitted by the state to CMS for buy-in is processed once a month, two working days before ABC month end. CMS then responds to this data, once a month, in the following month around the 10th or 12th of the month.

SSBI Menu Screen

SSBI menu is shown below. To view buy-in information for a specific person, enter either the Medicare claim number or the state identification number and press ENTER.

```
 SSBI                          IOWA DEPARTMENT OF HUMAN SERVICES   PAGE
                                      BUYIN SYSTEM MENU            TODAYS DATE   XX/XX/XX

TO DISPLAY INFORMATION ON THE BUYIN MASTER FILE, FILL IN
SSA CLAIM NUMBER OR STATE ID IN THE FIELDS PROVIDED BELOW,
AND DEPRESS THE ENTER KEY.




SSA CLAIM NUMBER                    STATE ID                    LINK
CLEAR KEY = END SESSION
MESSAGES:
```

Buy-in Master File Inquiry Screen

The Buy-in Master File screen displays the most recent buy-in activity.

```
 SSBI                          IOWA DEPARTMENT OF HUMAN SERVICES   PAGE
                                   BUYIN MASTER FILE INQUIRY       TODAYS DATE   XX/XX/XX

      FOR:

            SOC. SEC.     DOB     SEX   MEDICARE ENTITLE DATE

      CASE INFORMATION:
      STATE ID   CASE NUMBER    AID TYPE   ELIG CODE   COUNTY   WORKER    SPEC PROC

      PART B STATUS  X  XXXXXXXXXXXXX  X     BUYIN  XX-XXXX     BUYOUT  XX-XXXX
         TRANS DATE  XX-XXXX

      PART A STATUS  X  XXXXXXXXXXXXX  X     BUYIN  XX-XXXX     BUYOUT  XX-XXXX
         TRANS DATE  XX-XXXX
      REMIT OR REFUND AMOUNT  XXX.XX

SSA CLAIM NUMBER                    STATE ID XXXXXXXX            LINK
CLEAR=END          PF1=MENU                                    PF8=HISTORY
MESSAGES:
```

The Buy-in Master File includes the following information:

- **FOR** displays the client's first name, initial, and last name.
- **SOC. SEC.** displays the client's social security number.
- **DOB** displays the client's date of birth.
- **SEX** displays the client's sex (M or F).
- **MEDICARE ENTITLEMENT DATE** displays the month and year the client became entitled to Medicare.
- **STATE ID** displays the client's state identification number.
- **CASE NUMBER** displays the client's case number.
- **AID TYPE** displays the client's aid type.
- **ELIG CODE** indicates the reason the client is eligible for buy-in (used in determining federal financial participation).

  Mandatory buy-in codes are:

  L Specified low-income Medicare beneficiary (SLMB)
  M Entitled to Medicaid only (non-cash recipients who are not QMBs)
  P Qualified Medicare beneficiary (QMB)
  U Expanded SLMB

  Optional buy-in eligibility codes are:

  C Entitled to Part A of Title IV (AFDC)
  Z Deemed categorically needy

  Federally generated buy-in eligibility codes (based on the SSI record) are:

  A Aged recipient of federal SSI payments
  B Blind recipient of federal SSI payments
  D Disabled recipient of federal SSI payments
  E Aged recipient of supplemental payment administered by Social Security
  F Blind recipient of supplemental payment administered by Social Security
  G Disabled recipient of supplemental payment administered by Social Security
  H Aged, blind, or disabled recipient of a one-time payment

- **COUNTY** is the county number for the county carrying the person's case.
- **WORKER** is the worker number for the worker carrying the person's case.
- **SPEC PROC** is a special processing code.
- **PART B STATUS**: The first entry reflects the current phase in relation to Part B, either "1 Buy-in" or "2 Buy-out," followed by a code indicating the reason for the status. Valid codes are:

  1 Pending
  2 Complete
  3 Future
  4 Social Security Administration pending (reject)
  5 Death

- **BUY-IN** date represents the first month the premium was paid.
- **BUY-OUT** date represents the last month the premium was paid.
- **TRANSACTION DATE** is the month and year that the latest transaction was done.
- **PART A STATUS** includes the same fields as for Part B. The status may be "1 Buy-in," "2 Buy-out," or "none found." This may be followed by a descriptive code:

  1 Pending
  2 Complete
  3 Future
  4 Social Security Administration pending (reject)
  5 Death

- **BUY-IN** date represents the first month the premium was paid.
- **BUY-OUT** date represents the last month the premium was paid.
- **REMIT OR REFUND AMOUNT** represents the amount the state is being billed for a buy-in. (You can use this information to estimate the amount of refund the client will receive if the client previously paid premiums). On a buy-out, this amount represents the refund due the state.
- **MESSAGES** indicates if there are multiple records for the individual.

Buy-in History File Inquiry Screen

The Buy-in History file can be accessed through SSBI screen (if a record exists) by pressing the PF8=HISTORY key.

```
SSBH XXXXXXXXXX          IOWA DEPARTMENT OF HUMAN SERVICES    PAGE
                           BUYIN HISTORY FILE INQUIRY         TODAYS DATE  XX/XX/XX

NAME:  LAST      FIRST    I          SOC. SEC.        DOB              SEX

XXXXXXXXXX  XXXXXXX   X            XXX XX XXXX      XX XX XXXX       X

STATE ID          CASE NUMBER              COUNTY        WORKER

XXXXXXXXXX        XXXXXX XX XX               XX            XXXX

HISTORIES:  STATE CODE/DESC.        START     STOP     ELIG CODE   BUYIN  LAST UPD
    IOWA      XXX  XXXXXX           XX-XXXX   XX-XXXX      X         X     XX-XXXX
    HCFA      XXX  XXXXXX           XX-XXXX   XX-XXXX      X         X     XX-XXXX
    IOWA      XXX  XXXXXX           XX-XXXX   XX-XXXX      X         X     XX-XXXX




CLEAR=END          PF1=MENU                                  PF8=RETURN (SSBI)
MESSAGES:
```

This screen contains the following fields:

- **SSBH** displays the client's Medicare claim number.
- **NAME** displays the client's last name, first name, and initial.
- **SOC. SEC.** displays the client's social security number.
- **DOB** displays the client's date of birth.
- **SEX** displays the client's sex (M or F).
- **STATE ID** displays the client's state identification number.
- **CASE NUMBER** displays the client's case number.
- **COUNTY** is the county number for the county carrying the person's case.
- **WORKER** is the worker number for the worker carrying the person's case.

- **HISTORIES** tells what agency provided the information: CMS or Iowa.
- **STATE CODE/ DESC** gives a code and name of the state.
- **START** gives the month and year that buy-in began.
- **STOP** gives the month and year that buy-in stopped.
- **ELIG CODE** identifies the reason for federal financial participation in the buy-in.

  Mandatory buy-in codes are:

  L Specified low-income Medicare beneficiary (SLMB)
  M Entitled to Medicaid only (non-cash recipients who are not QMBs)
  P Qualified Medicare beneficiary (QMB)
  U Expanded SLMB

  Optional buy-in eligibility codes are:

  C Entitled to Part A of Title IV (AFDC)
  Z Deemed categorically needy

  Federally generated buy-in eligibility codes (based on the SSI record) are:

  A Aged recipient of federal SSI payments
  B Blind recipient of federal SSI payments
  D Disabled recipient of federal SSI payments
  E Aged recipient of supplemental payment administered by Social Security
  F Blind recipient of supplemental payment administered by Social Security
  G Disabled recipient of supplemental payment administered by Social Security
  H Aged, blind, or disabled recipient of a one-time payment

- **BUYIN** identifies whether the buy-in is for Part A or Part B of Medicare.
- **LAST UPD** for an Iowa entry is the date when the buy-in was added. For a CMS entry, it is the date Iowa received the history file from CMS.
- **MESSAGES** indicates if there are multiple records for this person.

SSNI = MEDICAID ELIGIBILITY FILE

The ABC System passes data to the Medicaid Eligibility System and the Individualized Services Information System (ISIS). This file is transmitted daily. Some data is, in turn, transmitted to other parts of the Medicaid Management Information System (MMIS).

- The eligibility information on MMIS is updated the day after the data is received from the SSNI Medicaid Eligibility file.
- The Eligibility Verification System (ELVS) is updated the same day MMIS is updated.
- The Point of Sale (POS) Eligibility System is updated the day after MMIS or ELVS has updated.

SSNI screens are available for review of Medicaid data. The screens display Medicaid eligibility information used to process provider claims for services other than facility care. SSNI displays:

- Medicaid eligibility information for an individual (Title XIX inquiry)
- Medicaid eligibility counts for the current and prior month (Title XIX count display)

SSNI links to the following systems:

- MEPD (Medicaid for Employed People with Disabilities)
- MIPS (Medicaid IowaCare Premium System)

The SSNI menu is shown below. To view the eligibility information for a client, place an 'X' in front of selection 1 and press the ENTER key.

```
DIALOG:                                                    PAGE: 1 OF 1
DATE:99/99/9999              SSNI SELECTION MENU           NEXT PAGE:

      _____1                 (ENTER)     TITLE XIX INQUIRY
      _____3                 (PF3)       TITLE XIX COUNT DISPLAY
      _____7                 (PF7)       LINK
      _____QUIT              (CLEAR)     EXIT




RESPONSE:                    SEND DATA - ->                MODE:  STEP
```

If you are on a person's ABC TD03 screen and then enter CODE/SCREEN option 3 SSNI, you move to the SSNI Menu screen. Place an 'x' in front of selection 1 and press the ENTER key to display the eligibility information for the person. Otherwise, SSNI screen 1 returns with a message prompt to enter a state identification number. Type in the state identification number for the desired person and then press the ENTER key. The following screen is returned:

```
XXXXXXX                              CASE NO                          UPDATED 000000   TYPE
                                                                MHC
MM/YY  RC   AID  F  INS   SP  CASE NO   SD  PR  LC  PP MP  CD  MHC   PROV & OPT  OR LOCKIN PROV




BEGIN MEDICAID    END MEDICAID    CASE APPL    CASE CERT    LAST ID    BIRTHDATE     WORKER
000 00 00 00      000 00 00 00    00 00 00      00 00 00    00 00 00   00 00 0000

                                                  PF1 MENU                PF2-PG 2X
                          SCREENING               SOCIAL SECURITY                 PF5-DETL MNTH
 BUY-IN X  BUY-OUT X  INITIAL X   CURRENT X        ACCT NO                         PF6-TPL HIST
 00 00 00   00 00 00  00 00 00    00 00 00         CLAIM NO                        PF10-MMCR
                                                                                  PF11-MIPS
                                                                                  PF12-MEPD          238
```

The 'page one' screen reflects eligibility information for the most recent 12 months. This includes any lock-in or managed health care (MHC) information for these months. **Note:** You can view the SSNI monthly details file for a given month by placing the cursor on the month and pressing the PF5-DETL MNTH key. See DETL MNTH Screen for information on the screen.

Please note the following items:

- **RC** is the county of residence.
- **AID** is the medical aid type. See 14-B-Appendix, TD01 MED AID, for codes, except for pre-existing chronic condition group, family planning waiver cases, breast and cervical cancer treatment (BCCT), IowaCare hardships, and foster care and adoption cases.

  The presumptive and ongoing BCCT aid type of 37-3 is entered through the PRSM screen.

For the pre-existing chronic condition group, the Medicaid type of 77-7 is entered through the PRSM screen or is entered by the Quality Assurance Unit when processing a *Request for Special Update*, form 470-0308.

The family planning waiver aid type of 90-6 is entered on SSNI through the Family Planning Waiver system.

For IowaCare members declaring hardship, SSNI converts the worker entered aid type to:

- 60-H for the IowaCare 200% group for people ages 19 to 64 hardship (formerly 60-E).
- 60-T for the IowaCare 300% group for pregnant and newborns hardship (formerly 60-P).

For members with concurrent eligibility under two or more limited benefit aid types, the TXIX system enters a "blended" aid type on SSNI. IM workers **are not** to enter blended aid types. The "blended" aid types and the applicable coverage groups are shown below:

Blended Aid Type	**Concurrent Eligibility Aid Types**		
	Coverage Group 1	Coverage Group 2	Coverage Group 3
86E	60E, IowaCare 200%	906,Family planning	
86H	60H, IowaCare 200% hardship	906, Family planning	
88E	60E, IowaCare 200%	888, Pregnancy presumptive	
88H	60H, IowaCare 200% hardship	888, Pregnancy presumptive	
88P	60P, IowaCare OB/NB	888, Pregnancy presumptive	
88T	60T, IowaCare OB/NB hardship	888, Pregnancy presumptive	
88F	906, Family planning	888, Pregnancy presumptive	
89E	60E, IowaCare 200%	889, BCCT presumptive	
89H	60H, IowaCare 200% hardship	889, BCCT presumptive	
89P	60P, IowaCare OB/NB	889, BCCT presumptive	
89T	60T, IowaCare OB/NB hardship	889, BCCT presumptive	
89F	906, Family Planning	889, BCCT presumptive	
8PE	60E,IowaCare 200%	906, Family planning	888, Preg presump
8PH	60H, IowaCare 200% hardship	906, Family planning	888, Preg presump
8BE	60E, IowaCare 200%	906, Family planning	889, BCCT presump
8BH	60H, IowaCare 200% hardship	906, Family planning	889, BCCT presump
87P	777, Chronic care DSH	888, Pregnancy presumptive	
87B	777, Chronic care DSH	889, BCCT presumptive	

The family planning waiver aid type of 90-6 is entered on SSNI through the Family Planning Waiver system.

For foster care and adoption cases, the Quality Assurance Unit enters the SSNI aid type based on the characteristics of the FACS and ABC cases, as follows:

MEDICAL AID TYPE	SSNI AID TYPE	FUND CODE
IV-E Foster Care 30-8 IV-E Medicaid	42-1 Foster family 42-3 Foster group 42-8 Shelter care 42-9 Interstate IV-E foster care	2 Child, receives maintenance payment
Presubsidy or Subsidized Adoption 30-8 IV-E Medicaid 64-0 SSI, disabled	46-2 Subsidized adoption 46-4 Presubsidy 46-5 Interstate IV-E adoption	2 Child, receives maintenance payment C Child, Medicaid only
CMAP 37-2 Child Medical Assistance Program 37-4 CMAP-Refugee	40-1 Foster family 40-3 Foster group 40-8 Shelter care 40-7 Independent 43-1 Foster family* 43-3 Foster group* 43-8 Shelter care* 43-7 Independent* 46-1 Subsidized adoption 46-3 Presubsidy * Payment-only (JCO) case	R Child, CMAP
Mothers and Children 92-0 MAC	40-1 Foster family 40-3 Foster group 40-8 Shelter care 40-7 Independent 43-1 Foster family* 43-3 Foster group* 43-8 Shelter care* 43-7 Independent* 46-1 Subsidized adoption 46-3 Presubsidy * Payment-only (JCO) case	A Adult, Medicaid only (pregnant woman regardless of age) C Child, Medicaid only

MEDICAL AID TYPE	SSNI AID TYPE	FUND CODE
Medically Needy 37-E Medically Needy 37-F Medically Needy-Refugee	40-1 Foster family 40-3 Foster group 40-8 Shelter care 40-7 Independent 43-1 Foster family* 43-3 Foster group* 43-8 Shelter care* 43-7 Independent* 46-1 Subsidized adoption * Payment-only (JCO) case	C FIP-related child, medical only R CMAP-related child, medical only
SSI 64-0 SSI, disabled	41-1 Foster family 41-3 Group care 41-8 Shelter care 41-7 Independent living 46-2 Subsidized adoption 46-4 Presubsidy 48-1 Foster family 48-3 Group care 48-8 Shelter care 48-7 Independent living 46-2 Subsidized adoption 46-4 Presubsidy	2 Child, receives cash assistance
Unaccompanied Refugee Minors (URMs) 06-3 Refugee Medical Assistance Only	02-1 Foster family 02-3 Foster group 02-8 Shelter care 02-7 Independent	2 Child, receives cash assistance
Children Who Do Not Qualify for Federally Funded Medicaid 40-9 State-only medical assistance	40-1 Foster family 40-3 Group care 40-8 Shelter care 40-7 Independent 43-1 Foster family* 43-3 Group care* 43-8 Shelter care* 43-7 Independent* 46-1 Subsidized adoption 46-3 Presubsidy 40-9 Medical only case	4 Child, state-only medical assistance

- **F** is the fund code. See 14-B-Appendix, TD03 FUND, for valid codes.
- **INS** shows whether the client has any health insurance other than Medicaid. See 14-B-Appendix, TD03 HEALTH**,** for valid codes for the first, third, and fourth position. For the second position, the following system-generated values may be found:

  D Indicates Part D coverage.

  X Indicates recipient has 'confirmed' (from the Part D MMA response file) Medicare Part A or Part B coverage, but no Part D coverage. An 'X' will be present only on eligibility months 01/2006 and later.

  W Indicates that ABC has indicated Part A or B coverage, but has not been 'confirmed' by information received from CMS.

  N Recipient has 'affirmatively declined' Part D coverage.

- **SP** is the special claims processing field, which identifies a person whose claims need to be processed in a unique way, i.e., enhanced services, illegal aliens, or qualified Medicare beneficiaries. A "J" in this field indicates that the person is covered under the state supplement for Medicare and Medicaid eligibles group. (See 14-B-Appendix, TD03 SRV, for other codes.)
- **SD** indicates whether the client's case has spenddown or not for the month.
- **PR** is the Medically Needy program relationship. (See 14-B-Appendix, TD03 MN, for codes.)
- **LC** is the county of legal settlement to be billed for services. If the member is receiving MR waiver, BI waiver, ARO, or ICF/MR services, then the county of legal settlement is passed to the TXIX system from the ISIS system. Otherwise, the field is populated with the information from ABC COS field on TD03.
- **PP** is the percentage of the federal poverty level represented by the recipient's income.
- **MP** shows the type of foster care Medicaid eligibility the recipient has, or the code for transitional Medicaid that shows the number of months of eligibility. Valid codes are:

  F IV-E
  G FMAP cash grants
  H CMAP
  I MAC
  K Other FMAP-related
  L SSI and SSI-related
  M PMIC

N State only
P Refugee Resettlement Program
0 Transitional Medicaid, no extended Medicaid coverage
1 Transitional Medicaid, first six months (additional allowed)
2 Transitional Medicaid, second six months
3 Transitional Medicaid, first six months (no additional allowed)
4 Extended coverage but not transitional Medicaid

♦ **MHC CD** designates the type of alternate delivery organization in which the client participates. The MHC code may reflect the client's participation in one or more of the following Medicaid programs:

- Iowa Plan for Behavioral Health (implemented January 1999)
- Health maintenance organization (HMO)
- Medicaid Patient Access to Services System (MediPASS)
- Lock-in program

The following codes are used for months of service beginning January 1, 1999:

A FMAP, ages 0-17, Iowa Plan
B FMAP, ages 18-64, Iowa Plan
C FMAP, ages 0-17, Iowa Plan, HMO
D FMAP, ages 18-64, Iowa Plan, HMO
E FMAP, ages 0-17, Iowa Plan, MediPASS
F FMAP, ages 18-64, Iowa Plan, MediPASS
G FMAP, ages 0-17, Iowa Plan, lock-in
H FMAP, ages 18-64, Iowa Plan, lock-in
J SSI, ages 0-17, Iowa Plan
K SSI, ages 18-64, Iowa Plan
L SSI, ages 0-17, Iowa Plan, lock-in
M SSI, ages 18-64, Iowa Plan, lock-in
N SSI, ages 0-17, Iowa Plan, HMO
P SSI, ages 18-64, Iowa Plan, HMO
Q SSI, ages 0-17, Iowa Plan, MediPASS
R SSI, ages 18-64, Iowa Plan, MediPASS
S Dual Medicaid and Medicare, age 0-64, Iowa Plan
T Dual Medicaid and Medicare, age 0-64, Iowa Plan, lock-in
V Foster care, PMIC, or MHI and lock-in, ages 0-22, Iowa Plan
W Foster Care, PMIC, or MHI, ages 0-9, Iowa Plan
X Foster Care, PMIC, or MHI, ages 10-22, Iowa Plan

0 Any coverage group, any age, no alternate delivery organization
1 Any coverage group, any age, HMO, no Iowa Plan
2 Any coverage group, any age, lock-in, no Iowa Plan
4 Any coverage group, any age, MediPASS, no Iowa Plan

Beginning July 1, 2001, new MHC codes V, W, and X are added to designate Iowa Plan coverage for children in foster care, PMIC, MHI, and lock-in. Before that date, children in foster care, PMIC, and MHI were included as FMAP, ages 0-17, Iowa Plan, codes A or G.

- **MHC PROV & OPT OR LOCKIN PROV** is the number associated with the provider for either managed health care or lock-in. This is a two-digit number following the plan for an HMO or a seven-digit number for MediPASS or lock-in.

  A client may be 'locked in' to up to four providers in a given month. A client may participate in up to three alternate delivery organizations in a given month. However, the combination of lock-in and alternate delivery may never exceed four in any month.

- **BEGIN MEDICAID** is the first date the client was eligible for Medicaid.

- **END MEDICAID** is the date the client died. This date shows zeros until the date of death is entered.

- **CASE APPL** is the original date of Medicaid application.
- **CASE CERT** is for central office use.
- **LAST ID** is the date on which the system last created a medical ID card.
- **BIRTHDATE** is the member's date of birth.
- **WORKER** is the worker number of the worker carrying the member's case.
- **SOCIAL SECURITY ACCT NO** is the member's social security account number.
- **SOCIAL SECURITY CLAIM NO** is the member's social security claim number.

The PF function keys displayed are:

PF1-MENU	Moves you to the main menu of the SSNI-Medicaid Eligibility File.
PF2-PG2	Moves you to SSNI Medicaid Eligibility File for the preceding 12 months of eligibility.
PF5-DETL MNTH	Moves you to the specified SSNI detail monthly screen to view specific information for a month.
PF6-TPL HIST	Moves you to the TPL history screen for the current month.
PF10-MMCR	Moves you to the Medicare Beneficiary Selection if the member's State Identification (SID) number is in the Medicare database.
PF11-MIPS	Moves you to the MIPS main menu screen.
PF12-MEPD	Moves you to the MEPD main menu screen.

To access the 'PG2' screen to view the preceding 12 months of eligibility, press the PF2 key. The following screen is displayed. It includes demographic and address data.

```
  xxxxxxx                          CASE NAME                                  WORKER CO
                                                                    MHC
MM/YY   RC  AID   F   INS  SP   CASE NO    SD   PR   LC   PP   MP  CD  MHC  PROV & OPT OR LOCKIN PROV




SEX          ETHNIC       HANDICAP       RECIPIENT ADDRESS-                    PF1- MENU  PF2-PG 1
                                                                                          PF5-DETL MNTH
                                                                                          PF6-TPL HIST
US     ID                                                                                 PF10-
MMCR
<SHIFT-PF1>=US LIST                                                                    PF11-MIPS
<SHIFT-PF2>=ID LIST                                                                    PF12-MEPD
                                                                                                ###
```

DETL MNTH Screen

The DETL MNTH screen displays detailed information for a state identification number for a selected month on the SSNI screen. The screen displays the primary eligibility listed on SSNI (page 1 or page 2), plus all the underlying eligibility (all eligibility sent from the ABC system) and all transactions entered on the MEPD RETR screen on either a daily batch process or in the month end process.

```
XXXXXXXX  XXXXX, XXXXX                    DOB 99/99/9999 X

MEDICAID FOR  99/9999                      UNDERLYING ELIGIBILITY
AID  XXX   FUND X   XXXXX                  AID  F  SP  SD  PR  MP  MHC  WV  P/M  FAC #      CAID  DATE
                                           XXX  X  X    X   X   X   X    X   X    XXXXXXX   XXX   99/99/9999
CASE NO    XXXXXXXXX  XX                   XXX  X  X    X   X   X   X    X   X    XXXXXXX   XXX   99/99/9999
                                           XXX  X  X    X   X   X   X    X   X    XXXXXXX   XXX   99/99/9999
CASE AID     XXX                           XXX  X  X    X   X   X   X    X   X    XXXXXXX   XXX   99/99/9999
WKR #/CO    XXXX  XX                       XXX  X  X    X   X   X   X    X   X    XXXXXXX   XXX   99/99/9999
MN SPEND DOWN
SPEC PROCESS                                 MEDID DATE   99 / 99 / 9999
                                             MEDID AID      XXX  XXX
       ENH SERV      ALIEN
       QMB/SLMB      $1 SUPP                                          SYS DATE   99/99
PROGRAM REL
MED PROGRAM                                IOWA PLAN     BF    X                  ONLINE UPDATE
MED STATUS        X                        PMIC/MHI IND                   BY          ON  99 99 9999
RES CO     XX     BILL CO   XX            FACILITY NO                    BY          ON  99 99 9999
                                           XXXXXXX
CO-PAY IND                                 PCT POV        XXX                    BATCH UPDATE
HAWK-I                                     WAIVER IND                     TYPE D      ON  99 99 9999
MHC TYPE    XXXXXXXX                                                      TYPE        ON  99 99 9999
XX XXXXXXX XXXXXXXXXXXXXXXXX
XX XXXXXXX XXXXXXXXXXXXXXXXX

                                             PF1 – MAIN MENU          PF5 - RETURN
                                                                                        283
```

Screen data and field descriptions:

- The person's state identification (ID) number and name in last name, first name order appear at the top of the screen.
- **DOB** is the recipient's date of birth in MM/DD/YYYY format.
- The one-byte field to the right of DOB denotes the person's sex. F = female; M = male.
- **MEDICAID FOR** is the month and year of eligibility.
- **AID** is the medical primary aid type.

- **FUND** is the fund code for the medical primary aid type. See 14-B-Appendix, TD03 FUND, for valid codes.
- **UNDERLYING ELIGIBILITY FIELDS**
  - **AID (1-5)** is the underlying medical aid type.
  - **F (1-5)** is the fund code for underlying medical eligibility. See 14-B-Appendix, TD03 FUND, for valid codes.
  - **SP (1-5)** is the underlying eligibility special claims processing field. See 14-B-Appendix, TD03 QMB and TD03 SRV, for valid codes.
  - **SD (1-5)** indicates whether the client's case has a spenddown (value "Y") or does not have a spenddown (value "N") for the underlying eligibility for the month.
  - **PR (1-5)** is the underlying program relationship code for Medically Needy. See 14-B-Appendix, TD03 MN, for codes.
  - **MP (1-5)** shows the underlying type of foster care Medicaid eligibility the person has, or the underlying eligibility code for transitional Medicaid that shows the number of months of eligibility for primary eligibility. Refer to the description of the MP field at SSNI = MEDICAID ELIGIBILITY FILE for the valid codes.
  - **MHC (1-5)** is the managed health care code for the underlying medical coverage It displays the type of MHC coverage: spaces, "HMO," LOCK-IN," or "MEDIPASS"
  - **WV (1-5)** is the eligibility waiver indicator for the underlying medical coverage. See 14-B-Appendix, TD03 WVR, for valid codes.
  - **P/M (1-5)** is the underlying eligibility PMIC/MHI Indicator.
  - **FAC # (1-5)** is the facility, hospice, or waiver vendor number for the underlying coverage. See 14-B-Appendix.
  - **CAID (1-5)** is the case aid type for the underlying medical coverage.
  - **DATE (1-5)** is the date the underlying eligibility was processed or date of the last update.
- **CASE NO** is the Medicaid recipient's identifying case number. The person number will display after the case number. See 14-B-Appendix, TD03 PER.
- **CASE AID** is the primary case aid type.

- **WKR#/CO** is the four-digit number assigned to the worker who is responsible for the case along with the two-digit county number.
- **MN SPEND DOWN** indicates whether a Medically Needy spenddown is required for primary eligibility to exist. Valid codes are: "Y" for yes there is a spenddown and "N" for no there is no spenddown.
- **SPEC PROCESS** is the special processing field for primary eligibility. The fields below are included as part of this field. The entry in this field is based on a hierarchy established for special processing based on the following sub-fields.
  - **ENH SERV** is the enhanced service code. See 14-B-Appendix, TD03 SRV, for codes.
  - **ALIEN** is the alien code. See 14-B-Appendix, TD03 SRV, for codes.
  - **QMB/SLMB** is the QMB/SLMB code. See 14-B-Appendix, TD03 QMB for codes.
  - **$1 SUPP** is for clients receiving assistance through the supplement for Medicare and Medicaid eligibles group. If enrolled, a "J" will be present.
- **MEDID DATE** is the date medical card was issued.
- **MEDID AID** is the type of medical card. The space after the MEDID AID field gives the kind of card. Values are: "space," "QMB," "FFS," "HMO," "LOCKIN," or "MEDIPASS."
- **SYSTEM DATE** is the eligibility system date or "MNTH-END."
- **PROG REL** is the program relationship code for Medically Needy for primary eligibility. See 14-B-Appendix, TD03 MN, for valid codes.
- **MED PROGRAM** is the field that shows the type of foster care Medicaid eligibility the recipient has, or the code for TM indicating the number of months of eligibility for primary eligibility. Refer to SSNI = MEDICAID ELIGIBILITY FILE for the description of the MP field for the valid codes.
- **IOWA PLAN** indicates whether the person is enrolled in Iowa Plan. An entry beginning with a letter indicates the Iowa Plan; one starting with a number means the person is not in the Iowa Plan. The second position displays gender (F = female and M = male). (The third character is for central office use only and comes from the next space on the screen.)

- **MED STATUS** is used to identify the worker-determined status of the individual's Medicaid eligibility. See 14-B-Appendix, TD03 MED ST, for valid codes.
- **PMC/MHI IND** is for central office use only.
- **ONLINE UPDATE BY** is the user ID number for the last update processed on line by Quality Assurance for primary eligibility.
- **ONLINE UPDATE ON** is the date of the last update for primary eligibility processed on line by Quality Assurance.
- **ONLINE UPDATE BY (2)** is the user ID number of the last update processed on line.
- **ONLINE UPDATE ON (2)** is the date of the last update processed on line.
- **RES CO** is the Medicaid recipient's county of residence.
- **BILL CO** is the eligibility billing county.
- **FACILITY NO** is the facility, hospice, or waiver vendor number. See 14-B-Appendix, TD05 VENDOR.
- **CO-PAY IND** is code used to determine the recipient's copayment for medical services. See 14-B-Appendix, TD03 COPAY.
- **PCT POV** is the recipient's percent of poverty level.
- **HAWK-I** displays the code indicate whether the recipient was referred to Medicaid from ***hawk-i***. Y = Yes, ***hawk-i*** referral. N = Non ***hawk-i*** referral.
- **WAIVER IND** displays the type of waiver eligibility. See 14-B-Appendix, TD03 WVR, for valid waiver codes.
- **BATCH UPDATE TYPE** indicates which update process occurred. "M" is for monthly. "D" for daily.
- **BATCH UPDATE ON** is the date the last update of that type processed.
- **MHC TYPE** is the field used to display the type of managed health care coverage: spaces for none, "HMO," "LOCK-IN," or "MEDIPASS"
- The next space has a two-digit value that is for central office use only.
- The vendor number is displayed. The vendor number is a unique identifier for each provider that gives services in the Medicaid program.

- The name of the Medicaid provider is displayed.
- **PF1=MAIN MENU** moves you to the main menu of the SSNI-Medicaid Eligibility File.
- **PF5=RETURN** returns you to SSNI (screen 1 or 2) whichever you started at. The screen page where you initiated the PF-5 DETL MNTH of time.
- A display of informational and error messages may appear at the bottom of the screen.
- ### is a three–digit program code used by the Division of Data Management.

Title XIX Count Display

The TITLE XIX COUNT DISPLAY screen provides the total Medicaid eligibility file counts for the current month and the prior month on specified data elements. The current counts are updated by entries made in Quality Assurance and by daily processing. The prior month counts are updated in daily processing.

To access the TITLE XIX COUNT DISPLAY, press the PF3 key from the SSNI Selection menu. The system displays the following:

```
TITLE XIX COUNTS FOR PROCESS MONTH                    CURRENT COUNTS
TOTAL COUNTS
TOTAL ELIGIBLE RECIPIENTS                        TOTAL ELIGIBLE ON LOCKIN
TOTAL INELIGIBLE RECIPIENTS                      TOTAL ELIGIBLE IN AN HMO
TOTAL RECORDS                                TOTAL ELIGIBLE IN MEDIPASS
MONTH TO DATE COUNTS
TOTAL RECIPIENTS ADDED
TOTAL RECIPIENTS ENDED DUE DEATH
TOTAL RECIPIENTS MADE ELIGIBLE FOR CURRENT MONTH
TOTAL NUMBER OF PRIOR MONTHS MADE ELIGIBLE
                    PF1 = RETURN TO MAIN MENU
                    PF2 = DISPLAY PRIOR MONTH COUNTS
```

WIFS MESSAGES

This section contains information regarding WIFS messages. "WIFS" stands for "warnings, informational, fatal, and summary." WIFS messages are e-mail messages sent to inform workers that action may need to be taken on a designated system. Although WIFS E-mail indicates that it was sent from the SPIRS Help Desk, it is actually system generated.

WIFS messages inform the income maintenance worker that action may need to be taken on the MEPD billing system, MIPS billing system, on a case in the ABC system, or in ISIS. Three types of WIFS messages are sent to income maintenance workers:

- W = warning message: A "W" message indicates a possible problem with the billing system or a person's medical record. The worker needs to check the system to make sure all the information entered is correct.
- I = informational message: An "I" message alerts you to certain conditions or provides information important to you.
- F = fatal message: An "F" message notifies you that the billing system has not updated for an individual. You should take an action in order to allow the system to update.

The S = summary messages are not sent to income maintenance workers. These messages are by program and are printed in a report for use by data processing staff.

The following sections explain:

- The contents of a WIF message,
- The identification and resolution for messages issued from:
  - The ***hawk-i*** referral screens
  - ISIS
  - The MEPD billing system
  - The MIPS billing system
  - The SSNI (TXIX) system

(See 14-B-Appendix for an explanation of WIFS issued from the ABC system.)

Contents of a WIFS Message

Each WIFS E-mail you receive contains information about only one person. Each WIFS message contains the following information:

- Your worker number
- Your county number
- The client's state identification number
- The client's case name
- The client's case number
- The system that generated the message (HWKI, ISIS, MEPD, TXIX, or ABC)
- The type of message (warning, informational, or fatal)
- The program number (located after the type of message). For research purposes only.
- The WIFS message number (located after the program number). This number corresponds to the message that is included in the E-mail.
- A generic field that is used to relay specific information in addition to the WIFS message, such as an aid type, a benefit month, or a worker number/county number.
- The actual WIFS message that informs you of the reason the WIFS was issued.

hawk-i WIFS Messages

The table below shows all of the ***hawk-i*** eligibility-related WIFS messages an income maintenance worker could receive.

WIFS No.	Message Sent To Worker	Definition/Resolution
4000 HWKI	Medicaid for some/all of the children was denied/ canceled due to excess income	The specified case has a 92-0 aid type and has been canceled or denied using notice reason 205. This message reminds you that the children on the case are ineligible for Medicaid due to income exceeding the 133% of poverty. Complete a referral to the ***hawk-i*** program.

ISIS WIFS Messages

The table below shows all of the WIFS messages a worker could receive that are related to the Individualized Services Information System (ISIS). If you are unable to resolve the issue using information given below, contact the SPIRS Help Desk.

WIFS No.	Message Sent To Worker	Definition/Resolution
11001 ISIS	The existing pend must be closed in ISIS before pending another program.	One waiver program was still pending in ISIS when action to pend a different waiver program was entered in ABC. The ISIS system will accept only one pended program at a time. Decide which waiver you want to work through the workflow in ISIS and make sure that is the one that passed to ISIS.
11002 ISIS	The pend failed because the consumer is already active for the program.	The action to pend had the same waiver type as the waiver active in ISIS. This occurs if the waiver code is not changed when the action to pend is entered in ABC on a person that is active on another case for a waiver program.
11099 ISIS	Action taken did not pass to ISIS. Send request to ISIS field support.	Entries made to pend the case in ABC did not roll to ISIS.
21002 ISIS	Begin dates overlap.	The beginning date on the ABC activity to approve is earlier than the beginning date on the latest ISIS program request. Entries made to the case in ABC did not roll to ISIS.
21003 ISIS	Incorrect program type on approval.	The waiver code at the time approval was entered is not a valid waiver code. Entries made to the case in ABC did not roll to ISIS.
21004 ISIS	ISIS end date overlaps the begin date on this action.	The beginning date on the ABC approval is earlier than the end date on the latest ISIS program request. Entries made to the case in ABC did not roll to ISIS.

WIFS No.	Message Sent To Worker	Definition/Resolution
22001 ISIS	Begin dates overlap.	The beginning date on the ABC approval is earlier than the beginning date on the latest ISIS program request. Entries made to the case in ABC did not roll to ISIS.
22002 ISIS	ISIS end date overlaps the begin date on this action.	Entries made to approve the case in ABC did not roll to ISIS because there was an end date on ISIS that is later than the effective date on the ABC approval. Verify the end date on ISIS and ask to have it corrected if it is wrong.
22003 ISIS	A pend program request exists. Possible incorrect waiver type on this action.	The waiver code at the time approval was entered is different than the program request that is pending in ISIS. Check ISIS to make sure the right program was approved.
22004 ISIS	The most recent program request is a pend. Missing approval may need to be added.	The approval may not have passed to ISIS. Check ISIS to make sure the right program and effective date was approved in ISIS.
23099 ISIS	Action taken did not pass to ISIS. Sent the request to ISIS field support.	Entries made to change a provider number on the case in ABC did not "roll" to ISIS.
31001 ISIS	The eligibility record was not found. Missing approval may need to be added.	Client participation was changed but there was no active program request in ISIS. Check ISIS to make sure the program approved in ABC is approved in ISIS.
31002 ISIS	The eligibility record was not found. Missing approval may need to be added.	Client participation was changed but there was no active program request in ISIS. Check ISIS to make sure the program approved in ABC is approved in ISIS.

WIFS No.	Message Sent To Worker	Definition/Resolution
31003 ISIS	CP change. Begin dates overlaps ISIS dates. Complete vendor adjustment.	The beginning date on the ABC entries to change client participation is earlier than the beginning date on the latest ISIS program request. Entries made to the case in ABC did not roll to ISIS.
31004 ISIS	All eligibility is closed. Missing approval may need added before CP change.	Entries were made in ABC to change client participation on a case that is closed in ISIS. Check ISIS to make sure the program approved in ABC is approved in ISIS.
31005 ISIS	CP change. The program type must match ISIS.	The waiver code at the time client participation was changed is different than the program request that is active in ISIS. Check ISIS to make sure the right program is active.
31006 ISIS	CP change. ISIS already has the requested CP information.	The client participation change passed to ISIS already matches the client participation amount shown on the active program request in ISIS. Check ISIS to make sure all client participation amounts are correct.
31099 ISIS	Action taken did not pass to ISIS. Send the request to ISIS field support.	Entries made to change client participation on the case in ABC did not "roll" to ISIS.
31101 ISIS	CP correction. Program request not found.	Client participation was corrected but there was no active program request in ISIS. Check ISIS to make sure the program approved in ABC is approved in ISIS.
31102 ISIS	CP correction. Begin date overlaps ISIS date. Submit vendor adjustment form.	The beginning date in the ABC entries to correct client participation is earlier than the beginning date on the latest ISIS program request. Entries made to the case in ABC did not roll to ISIS.

WIFS No.	Message Sent To Worker	Definition/Resolution
31103 ISIS	CP correction. All program requests are closed.	Entries were made in ABC to correct client participation on a case that is closed in ISIS.
31104 ISIS	CP correction. The program type does not match ISIS.	Entries to correct client participation were made in ABC, but the program passed from ABC does not match program on the active ISIS program request.
32001 ISIS	Change of ownership. The program and provider must match.	When change of ownership takes place, central office staff will send instructions.
32002 ISIS	Change of ownership. The begin date must match.	When change of ownership takes place, central office staff will send instructions.
33001 ISIS	COLS change. The eligibility was not found.	The county of legal settlement was changed but there are no active program requests in ISIS.
33002 ISIS	Change is COLS. Begin date overlaps ISIS dates.	The county of legal settlement was changed and the beginning date passed from ABC is earlier than the beginning date on the latest program request in ISIS.
33003 ISIS	Change in COLS. All program requests are closed.	The county of legal settlement was changed but all program requests in ISIS are closed.
33004 ISIS	COLS change. The COLS matches ISIS.	The county of legal settlement was changed and the county entered in ABC already matches the county of legal settlement in ISIS.
34001 ISIS	The worker is not on ISIS or is not enabled.	The worker number was changed in ABC but the new worker does not have current access to ISIS. The supervisor will need to request access for this worker.

WIFS No.	Message Sent To Worker	Definition/Resolution
34002 ISIS	More recent eligibility already exists.	The worker number has changed. Verify that the worker assigned on the Roles page in ISIS is correct.
34003 ISIS	All program requests are closed.	The worker number has changed. Verify that the worker assigned on the Roles page in ISIS is correct.
34004 ISIS	No eligibility record found.	Worker number changed but there are no program requests in ISIS. Verify that the program approved in ABC is active in ISIS.
34005 ISIS	Worker county missing.	The worker number was changed but the worker county was left blank. Verify that the worker assigned in ABC matches the worker on the Roles page in ISIS.
34006 ISIS	Supervisor missing.	The IM worker number on the ABC case when entries were made does not have access to ISIS, and no supervisor is assigned to that worker's county in ISIS. The supervisor needs to make sure that: ♦ The supervisor is assigned to the correct county in ISIS; ♦ The IM worker has access to ISIS; and ♦ The worker number assigned to that worker for ABC is also assigned to that worker in ISIS.
40001 ISIS	Denial. There is no pended program request.	No program requests were pending in ISIS when the denial was passed from ABC. If the denial did get to ISIS, pend and then deny the case again in ABC.
40002 ISIS	Denial. Program types do not match.	This usually means that the waiver code on the TD03 screen was not correct when the denial was entered in ABC.

WIFS No.	Message Sent To Worker	Definition/Resolution
51001 ISIS	Cancellation. Eligibility not found. Missing program needs to be added.	Cancellation entries were made in ABC but there are no program requests in ISIS. Make sure any previous approvals for facility or waiver are correctly added to ISIS.
51002 ISIS	Cancellation. Eligibility not found. Missing program needs added.	Cancellation entries were made in ABC but there are no program requests in ISIS. Make sure any previous approvals for facility or waiver are correctly added to ISIS.
51003 ISIS	Cancel. Eligibility already cancelled. Check for missing program request.	Cancellation entries were made in ABC but all program requests in ISIS are already closed. Make sure any previous approvals for facility or waiver are correctly added to ISIS.
51004 ISIS	Cancel. No matching eligibility found. Check for missing program request.	Cancellation entries were made in ABC but the program requests for this waiver or facility type are already closed in ISIS. The TD03 screen may have had an incorrect waiver code when entries were made. Make sure the correct program request was closed in ISIS.
51005 ISIS	Cancel. Program types do not match. Possible incorrect waiver code.	Cancellation entries were made in ABC but the program requests for this waiver or facility type is already closed in ISIS. The TD03 screen may have had an incorrect waiver code when entries were made. Make sure the correct program request was closed in ISIS.
51099 ISIS	Action taken did not pass to ISIS. Send the request to ISIS field support.	Entries made in ABC did not “roll” to ISIS.
52001 ISIS	Cancellation. Eligibility not found. Check for missing program request.	Cancellation entries due to death were made in ABC but there are no program requests in ISIS. Make sure any previous approvals for facility or waiver are correctly added to ISIS.

WIFS No.	Message Sent To Worker	Definition/Resolution
52002 ISIS	Cancellation. Death date is prior to eligibility start date.	Entries were made in ABC to cancel the person due to death and the date of death entered is before the begin date of the waiver. Verify that the date of death entered is correct.
52003 ISIS	Cancel. Eligibility already cancelled. Check for missing program request.	Cancellation entries due to death were made in ABC but all program requests in ISIS are already closed. Make sure any previous approvals for facility or waiver are correctly added to ISIS.
52004 ISIS	Cancellation. Eligibility not found. Check for missing program request.	Cancellation entries due to death were made in ABC but there are no program requests in ISIS. Make sure any previous approvals for facility or waiver are correctly added to ISIS.
52099 ISIS	Action taken did not pass to ISIS. Send the request to ISIS field support.	Entries made in ABC to cancel due to death did not "roll" to ISIS.
61001 ISIS	Program eligibility not found. Check for missing program request.	Entries made to correct the provider number but there are no program requests in ISIS. Check to make sure the program approved in ABC is active in ISIS.
61002 ISIS	Correction. Program start date did not match.	Entries were made to correct the provider number but the beginning date on the program requests in ISIS does not match the date passed from ABC. Send request for correction of the provider number in ISIS.
62001 ISIS	Program eligibility not found. Check for missing program request.	Entries were made to correct client participation, but there are no program requests in ISIS. Check to make sure the program approved in ABC is active in ISIS.

WIFS No.	Message Sent To Worker	Definition/Resolution
62002 ISIS	Correction. Program start date did not match.	Entries were made to correct client participation, but the beginning date passed from ABC does not match the beginning date on the program requests in ISIS. Send a request for correction of client participation.
62101 ISIS	Program eligibility not found. Check for missing program request approval.	Entries were made to correct client participation, but there are no program requests in ISIS. Make sure the program approved in ABC is active in ISIS.
63001 ISIS	Program eligibility not found. Check for missing program request approval.	Entries were made to correct the aid type, but there are no program requests in ISIS. Check ISIS to make sure the program approved in ABC is active in ISIS.
63002 ISIS	Correction. Program start date did not match.	Entries were made to correct the aid type, but there are no program requests in ISIS. Check ISIS to make sure the program approved in ABC is active in ISIS.
90001 ISIS	A previous activity errored for this consumer. This was bypassed.	Check ISIS to make sure the information in ABC matches ISIS.
90002 ISIS	Residence county error.	The county of residence was invalid.
90003 ISIS	IABC action could not be interpreted in ISIS.	Check ISIS to make sure the information in ABC matches ISIS.
90004 ISIS	IABC action could not be interpreted in ISIS.	With message 99920, this message means that the aid type is for facility care but there was a waiver code on the TD03 screen when the entries were made, e.g., the aid type is 63-8, ICF/MR, but the waiver code is D for MR waiver.

WIFS No.	Message Sent To Worker	Definition/Resolution
90004 ISIS (Cont.)		With message 98904, this message means the aid type and provider or program type disagree. Verify that the correct waiver code and aid type were present when entries were made. With message 99921, this message means the facility waiver status on TD05 didn't match the facility waiver status for the person on TD05. Check to see if you entered the TD03 status but failed to enter the TD05 status. With message 99908, this message is sometimes received when you enter another change (such as correcting the waiver code) along with a client participation change. This message may also be received when the case used to approve a waiver includes additional inactive individuals. This message may also be received when entries are made on a consumer's TD01 or TD03 screen but no entries are made on the TD05 screen, so ISIS is unable to determine whether the action taken in ABC affects ISIS information.
90005 ISIS	Invalid provider number, or provider number found on HCBS waiver activity.	This message most commonly occurs when the waiver code is not changed at the time actions are entered on a person who is pending on a waiver and active for facility. It is also issued when the person is active on waiver and facility care is pended without changing the waiver code.

WIFS No.	Message Sent To Worker	Definition/Resolution
90006 ISIS	Action taken did not pass to ISIS. Send the request to ISIS field support.	With message 98902, this message means the vendor number and waiver code are an invalid combination. For example, when the vendor number is blank, this indicates a waiver case so the waiver code can't be blank. For a facility case, the waiver code can be blank but a vendor number must be present. With message 98912, this message means the aid type was changed when the client participation was changed. Currently ISIS does not allow aid type changes at the same time as client participation is changed. With message 98915, this message means that IM entered an aid type change. Verify that the aid type is correct for the program and the person's age. With message 99901, this message means that there was no individual on the case. If this is a hospital-only aid type (73-4), the case was pulled into ISIS in error and may be ignored. If this is an entry for death, it may be issued for other case numbers the deceased person was associated with in the person's lifetime. With 99966, this error means the positive date in ABC was invalid or missing. With message 99969, this message means that IM made entries on the TD05 screen that were left to roll to the TD03 screen. ISIS is sometimes unable to apply the activity when the TD03 individual entries are not actually entered. For example, the worker denied the case on TD05 and let the denial roll to the TD03, rather than making the A entry reason and M status entries on TD03.

WIFS No.	Message Sent To Worker	Definition/Resolution
90006 ISIS (Cont.)		The message may also be issued when: ♦ The waiver code was left blank when the denial of a waiver was entered. ♦ Information is entered for the same person on more than one case in the same day. ♦ The case is denied on the TD05 screen but no denial entries are entered in the TD03 screen. Denial entries roll to TD03 in ABC, but this may result in ISIS' inability to identify the individual.
99998 ISIS	A previous activity record errored for this consumer.	Check ISIS to make sure the information in ABC matches ISIS.
99999 ISIS	ISIS was not able to interpret your request.	Check ISIS to make sure the information in ABC matches ISIS.

MEPD WIFS Messages

The table below lists all of the MEPD-related WIFS messages an income maintenance worker could receive.

Note: MEPD 3001 is also sent to the worker's supervisor. This is a safeguard to ensure that action is taken to cancel the case before timely notice day, in the event that the worker is out of the office.

WIFS No.	Message Sent To Worker	Definition/Resolution
27 MEPD	No MEPD billing information for this state ID	The Medicaid Eligibility system has not received a premium record for the person from the ABC system. This usually occurs when there is more that one person on the active MEPD case. Review the case. Close the individual who is not the case-name person. Reopen that person on a separate ABC case if appropriate. If the person is not eligible for Medicaid, simply close the person on this case.
29 MEPD	No MEPD billing information for this elig. month	The Medicaid Eligibility system has not received a premium record for this month. This can occur when two people are on the same MEPD case. Review the case. Close the individual who is not the case-name person. Reopen that person on a separate ABC case if appropriate. If the person is not eligible for Medicaid, simply close the person on this case.
100 MEPD	Date invalid	ABC has transferred an invalid date. (The WIFS will indicate which date.) The correct date needs to be reentered into ABC.
101 MEPD	Field invalid	ABC has transferred an invalid code. The correct code needs to be reentered into ABC.

WIFS No.	Message Sent To Worker	Definition/Resolution
102 MEPD	Date not numeric	ABC has transferred a date that is not numeric. (The WIFS will indicate which date.) Correct the date in the ABC system.
103 MEPD	Field not numeric	ABC has transferred an alphabetical code in a field that must be numeric. (The WIFS message will indicate which field.) Correct the code in the ABC system.
3001 MEPD	MEPD 481 – Cancel case due to nonpayment of current month premium (Also sent to the worker's supervisor)	Cancel the case by the timely notice date, because the current month premium has not been paid by the due date.
3002 MEPD	MEPD – Late payment received – 484 reinstate or 485 reopen	Review the case and reopen or reinstate the case, because a late payment has been received for the current month. Only one reopening is allowed in a six-month period.
3003 MEPD	Positive action date less than 03/01/2000	The positive action date is before the beginning of the MEPD program. Correct the positive action date.
3004 MEPD	Approval date less than 03/01/2000	The positive action date is before the beginning of the MEPD program. Correct the positive action date.
3005 MEPD	Already active on TXIX for start month	Medicaid is already active for the month of positive action date.
3009 MEPD	ESTD/Fiscal agent to release spenddown	Reserved for future use.
3013 MEPD	Block paid month – possible recoupment	A paid month has been blocked on the MEPC screen. Determine if a recoupment is appropriate.

WIFS No.	Message Sent To Worker	Definition/Resolution
3016 MEPD	Requested refund greater than base credit	A refund has been issued for an amount that is greater than the credit amount in the MEPD system. Determine if recoupment is appropriate.
3020 MEPD	No months updated via ABC entry/see MEPC or RETR to update prior months	This message is issued when a re-application is completed on a MEPD case and the positive action date is for a month that is already established on MEPD. If the current system month has already been established on MEPD, the only month that has been updated on the MEPD system is the next system month. Change the premium amount for the current or prior months using the MEPC screen.
3021 MEPD	Only system month updated via ABC entry/see MEPC or RETR to update prior months	MEPD has been approved for a month that is already established on MEPD. The new premium did not update for the months before the current system month. (For example, in July, you approve MEPD with a positive date of June 1. If June is already established on MEPD, the system will not update June with the new premium. July, which is the current system month, will update with the new premium because it was never previously updated on MEPD.) Change the premium amount for the months before the current month using the MEPC screen.
3026 MEPD	Percent of poverty cannot be zero if income greater than zero	There is income entered on the RETRO screen for this person, but the poverty level entered is 000. Since this person has income, the poverty level must be greater than 0. Determine the poverty level and use the MEPC screen to correct it.

WIFS No.	Message Sent To Worker	Definition/Resolution
3047 MEPD	Premium payment received after automatic refund was issued in the previous month	Payment has been received, but there are no active months for which to apply it. This may happen if the client is canceled from MEPD but does not realize it and continues to pay a premium. Review the case and instruct the client to stop making payments if the case is closed.
3048 MEPD	Premium is invalid, month has been blocked. Please correct & unblock using MEPC.	The MEPD system has received a premium amount that is invalid for the month specified. This is because the case has been approved after an annual increase in the premiums and the ABC system used the new rates to calculate the premium for the specified month, which is before the effective date of the premium rate changes. The client will not receive a bill or be granted any medical eligibility until this month is corrected and unblocked. The system blocks only the months with an invalid premium amount. Enter the correct premium amount, unblock the month, and enter the appropriate income for the specified month all at the same time on the MEPC screen. The corrected months will show on the next billing statement generated.
3050 MEPD	Aid type now primary elig. MEPD past max due date.	This occurs when Medically Needy with a "P" fund code is in underlying eligibility with MEPD ('P' fund code) in primary eligibility. This WIFS message is generated when the time limit to pay the MEPD premium has gone past the MAX DUE DATE, so the 60-M record goes to underlying eligibility, and the 37-E 'P' becomes the primary eligibility.

WIFS No.	Message Sent To Worker	Definition/Resolution
3055 MEPD	Mnth is inactive in MEPD system – use RETR screen to process medical eligibility	The month in the MEPD system has gone past its maximum due date, or there is already other medical eligibility on SSNI for this month. Verify that the client wants MEPD for this month and make entries on the RETR screen in the MEPD system to activate eligibility.
3056 MEPD	Premium is invalid for month/year stated. Use MEPC to correct premium.	The MEPD system has determined that the client has been billed an incorrect premium amount for the specified month and may already have received Medicaid eligibility for the month. This may occur when the annual increase in premiums is implemented and the month's premium is determined using the incorrect calculations. Correct the premium amount and income using the MEPC screen. Recoup the difference between what has been paid and the total amount owed.

MIPS WIFS Messages

The table below lists all of the MIPS-related WIFS messages an income maintenance worker could receive.

WIFS No.	Message Sent To Worker	Definition/Resolution
27 MIPS	No MIPS billing information for this state ID	The MIPS billing system has not receive a premium record from the ABC system for this member. Review the case. Determine why a premium record was not generated from ABC. Resubmit the ABC entry or make entries on the RETR screen to update MIPS.
29 MIPS	No MIPS billing information for this elig. month	The MIPS billing system has not received a premium record from the ABC system for this member. This could be due to either: ♦ Entry of a RETRO code on TD05 **after** the IowaCare case has been approved on ABC, or ♦ Entry that backdates medical eligibility on the TD03. Use the RETR screen to add this month for billing.
100 MIPS	Date invalid	ABC has transferred an invalid date. (The WIFS will indicate which date.) The correct date needs to be reentered into ABC.
101 MIPS	Field invalid	ABC has transferred an invalid code. The correct code needs to be reentered into ABC.
102 MIPS	Date not numeric	ABC has transferred a date that is not numeric. (The WIFS will indicate which date.) The date needs to be corrected in the ABC system.

WIFS No.	Message Sent To Worker	Definition/Resolution
103 MIPS	Field not numeric	ABC has transferred a code that must be numeric and an alphabetical code was passed instead. (The WIFS message will indicate which field.) The code needs to be corrected in the ABC system.
3002 MIPS	MIPS – late payment received, hardship, death, or other Medicaid elig overlaid IACare. Possible reinstate/reopen/refund. Check elg code on SUMM screen. Take appropriate action.	This is generated when: ♦ A late payment is received, ♦ A hardship is granted, ♦ An IowaCare member dies, or ♦ Other full Medicaid eligibility overlays IowaCare. Determine what action to take: reinstate/reopen or authorize refund.
3003 MIPS	Positive action date less than 07/01/2005	The positive action date is before the beginning of the IowaCare program. Correct the positive action date.
3004 MIPS	Approval date less than 07/01/2005	The positive action date is before the beginning of the IowaCare program. Correct the positive action date.
3005 MIPS	Already active on TXIX for start month	Medicaid is already active for the month of positive action date.
3013 MIPS	Block paid month – Possible recoupment	Someone has blocked a paid month. Therefore, the money is put back into the credit. Review the case to determine if a recoupment needs to be completed.
3016 MIPS	Requested refund greater than base credit	A refund has been issued for an amount that is greater than the credit amount in the MIPS system. Determine if recoupment is appropriate.

WIFS No.	Message Sent To Worker	Definition/Resolution
3020 MIPS	No months updated via ABC entry/see MIPC or RETR to update prior months	A re-application was completed on a MIPS case and the positive action date is for a month that is already established on MIPS. If the current system month has already been established on MIPS, the only month that has been updated on the MIPS system is the next system month. Change the premium amount for the current or prior months using the MIPC screen.
3021 MIPS	Only system month updated via ABC entry/see MIPC or RETR to update prior months	A premium has been approved for a month that is already established on MIPS. The new premium did not update for the months before the current system month. (Example: In July, you approve a premium with a positive date of June 1. If June is already established on MIPS, the system will not update June with the new premium. The current system month, July, will update with the new premium because it was never previously updated on MIPS.) Change the premium amount for the months before the current month using the MIPC screen.
3043 MIPS	Userid not on worker table – Retro not processed	Someone who does not have authorization to enter a month on the RETR screen attempted to enter eligibility. The system did not process it, as the person did not have authorization to make that entry.
3074 MIPS	Overlapping mandatory periods – Initial mandatory period remains in effect	MIPS has received a record overlapping a previous mandatory period already established on MIPS. The billing system will ignore the new mandatory period and simply process this premium record as normal.

WIFS No.	Message Sent To Worker	Definition/Resolution
3075 MIPS	New mandatory period record. Previous mandatory period is unpaid.	A case has been approved that should not have been approved because there are still months from a mandatory period that remain unpaid.
3076 MIPS	Mandatory start date different from positive action date	The record will be used. The oldest date will be used to set up eligibility months. (If the mandatory start date is before the positive action date, the record is treated as if the positive action date is the mandatory start date.) The mandatory period will start on the mandatory start date.
3078 MIPS	Transaction record received, transaction should not have been allowed due to unpaid month	MIPS has received a record of eligibility for a person who has unpaid premiums. MIPS has sent an automatic notification to the ABC system that premium payment has not been received, and the case must be closed due to nonpayment of premium. Review the case to determine if case should be closed or if it can remain open.
3084 MIPS	Hardship cannot be removed	Someone attempted to remove a hardship from a month. This action is not allowed.
3099 MIPS	Reported date of death – eligibility received for month after month of death. Please review case.	MIPS has received an eligibility record for a month after the month that has already been recorded in the TXIX system as the month of the client's death. The TXIX system has set up eligibility on SSNI and the MIPS system has also processed the information. Determine if the client is truly deceased or if you are correct in approving eligibility.

TXIX WIFS Messages

The table below shows all of the Medicaid eligibility-related WIFS messages an income maintenance worker could receive.

WIFS No.	Message Sent To Worker	Definition/Resolution
3000 TXIX	Med Needy w/SD and active aid type aid type – ESTD/IME MN unit to release spenddown	The Medicaid Eligibility system has received an active medical aid type and a Medically Needy record with spenddown for the same month. Ask the IME Medically Needy Unit to release the spenddown amount. See 14-I, Changes and Corrections.
3001 TXIX	Potential Med Needy with no spenddown	The Medicaid Eligibility system has received a Medically Needy record with a "P" fund code but no spenddown amount. Either enter spenddown needs in the ABC system, or correct the fund code.
3002 TXIX	Aid type becomes primary aid type over Med Needy w/no spenddown	There is already active Medically Needy eligibility on SSNI when another active medical record is received for the same benefit month. The active medical aid type will be the primary eligibility on SSNI for that month.
3004 TXIX	Foster care/adoption & MN/SD. ESTD/IME MN unit to release SD for the month of FC/A eligibility	A foster care or adoption record and a Medically Needy record with spenddown have been received for the same month. Determine if the Medically Needy case should remain open. Notify the IME Medically Needy Unit to release the spenddown for the month that foster care or adoption eligibility has been approved. See 14-I, Changes and Corrections.

WIFS No.	Message Sent To Worker	Definition/Resolution
3005 TXIX	Foster care/Adopt – primary aid type active – no accompanying active aid type	When foster care is approved for a child, the Medicaid Eligibility system should receive two records to process: the foster care record and a medical record. If the system does not receive both records, it will not be able to process eligibility. This WIFS message informs you the Medicaid Eligibility system was unable to process medical eligibility without the two records. Determine which record was not received.
3006 TXIX	Aid type not valid with Foster care/adoption. No active medical eligibility.	The Medicaid Eligibility system has received a foster care or adoption record and no valid medical record. The medical record the Medicaid Eligibility system has received is either a Medically Needy case with a spenddown or an MEPD case with a premium. If a child is approved for foster care or adoption medical, Medically Needy with a spenddown or MEPD with a premium is not allowed. The medical eligibility has to be approved under a different aid type, or Medically Needy without a spenddown, or MEPD without a premium.
3007 TXIX	Review all addresses on active ABC cases. All addresses must match.	This message informs you that the addresses received for one person for a specific month do not match on all medical cases. Correct the addresses on the ABC system so all addresses are written the same. This is to ensure that the billing statements are mailed to the correct address. This message pertains only to medical records. If a person has a separate Food Assistance case, the Food Assistance case is not included.

WIFS No.	Message Sent To Worker	Definition/Resolution
3012 TXIX	Facility & MEPD, review all cases. Determine if all cases should remain open.	The Medicaid Eligibility system has received a facility record and a MEPD record for the same benefit month. The system assumes the facility eligibility is based on MEPD. If the MEPD premium is not paid, MEPD stays in as the primary eligibility and facility is the underlying eligibility. Once the premium is paid, the facility record will become the primary eligibility and MEPD will become the underlying eligibility. If the MEPD premium is $0, the facility record will be the primary eligibility and MEPD will be underlying. View both case records to verify that both cases should remain open.
3013 TXIX	Corrections required on ABC-Check DOB & aid type – Under age 65 with elderly aid type	This message contains the person's date of birth, age, and aid type. It is possible that the wrong aid type was used for this person or the wrong date of birth was entered in ABC. Check the aid type and date of birth and make corrections for the following month.
3015 TXIX	IowaCare eligibility cannot be established for months prior to 07/2005	The TXIX system has received an IowaCare eligibility record for a month that is before the start date of the program. The eligibility is not processed.
3016 TXIX	Medicaid for Independent Young Adults (MIYA) cannot be established for months prior to 07/2006.	The TXIX system has received a MIYA eligibility record for a month before the start date of the program. The eligibility is on processed.
3017 TXIX	Family planning Eligibility cannot be established for months prior to 02/2006.	The TXIX system has received an FPW eligibility record for a month before the start date of the program. The eligibility is not processed.

WIFS No.	Message Sent To Worker	Definition/Resolution
3020 TXIX	Eligibility month requested is more than 24 months ago	The Medicaid Eligibility system has received an eligibility record for a month that is more than 24 months before the current system month. The system can only hold 24 months. (For example, 3/05 back through 4/03. A record received in 3/05 for 3/03 cannot be processed.) Review the case to determine if an incorrect date was entered. If so, make ABC entries to generate a new record to be sent to the Medicaid Eligibility system.
3022 TXIX	Medical card was not generated – client's state-ID is not on SSNI	The Medicaid Eligibility system has received a record requesting reprinting of a medical card for a person who has no state ID number. This should never happen. If you receive this message, contact the SPIRS Help desk.
3023 TXIX	Medical card was not generated – no active eligibility on SSNI for month requested	The Medicaid Eligibility system has received a record requesting reprinting of a medical card for a month that has no active eligibility on the system. An entry has been made into the ID GEN field for a month that has no active eligibility in the Medicaid Eligibility system. Review the entry and reenter the appropriate code for the month the client wishes to have a medical card reprinted.
3040 TXIX	Invalid Medically Needy characteristic code on TD03 – enter valid code	ABC has sent a medical eligibility record to the Medicaid Eligibility system with an invalid MN characteristic code. Check the ABC entry and correct the MN characteristic code on TD03.

WIFS No.	Message Sent To Worker	Definition/Resolution
3041 TXIX	Invalid fund code – enter valid fund code	ABC has sent a medical eligibility record to the Medicaid Eligibility system with an invalid fund code. Check the ABC entry and correct the FUND code on TD03.
3042 TXIX	Invalid aid type – enter valid aid type	ABC has sent a medical eligibility record to the Medicaid Eligibility system with an invalid aid type. Check the ABC entry and correct the aid type on TD01.
3043 TXIX	Percent of poverty is invalid for QWDP	ABC has sent a record to the Medicaid Eligibility system with an invalid poverty level for QWDP. Check the ABC entry and correct the poverty level on TD03.
3044 TXIX	Percent of poverty is invalid – enter correct poverty level	ABC has sent a record to the Medicaid Eligibility system with an invalid poverty level for a 90-0 or 90-2 aid type with a QMB indicator of E, L, or Q. Check the ABC system and verify that the correct poverty level is entered. Change the QMB indicator to applicable code based on the poverty level.
3045 TXIX	QMB indicator is blank	ABC has sent a record to the Medicaid Eligibility system with spaces in the QMB indicator field. Check the ABC entry and enter the correct QMB indicator.
3046 TXIX	QMB ind of H not allowed – check poverty level, may be incorrect POV	ABC has sent a record to the Medicaid Eligibility system with a QMB indicator of "H" or the poverty level is incorrect in the ABC system. Correct the QMB indicator and/or the poverty level in ABC.

WIFS No.	Message Sent To Worker	Definition/Resolution
3047 TXIX	Facility aid type, no facility number received	ABC has sent a record to the Medicaid Eligibility system with a facility only aid type but no facility number. Enter the correct facility number in the WVR field on TD03 for this case. This will cause the Medicaid Eligibility system to update with the correct information.
3048 TXIX	Waiver aid type, no waiver indicator received	ABC has sent a record to the Medicaid Eligibility system with a waiver only aid type but no waiver indicator. Enter the correct code in the WVR field on TD03 for this case. This will cause the Medicaid Eligibility system to update with the correct information.
3049 TXIX	Facility/waiver aid type, no facility number or waiver indicator received	ABC has sent a record to the Medicaid Eligibility system with a facility or waiver aid type but no facility number or waiver indicator. Enter the correct facility number or waiver code in the WVR field on TD03 for this case. This will cause the Medicaid Eligibility system will update with the correct information.
3050 TXIX	Foster care and MEPD – MEPD billing stops/possible refund	The system has received an MEPD record and a foster care record for the same month. MEPD billing will be stopped for that month. Determine if a refund is due to the client for that month and close the MEPD case if appropriate.
3058 TXIX	ESTD/IME unit to release spenddown	The Medicaid Eligibility system has received an active MEPD record and a Medically Needy record with spenddown for the same month. Ask the IME Medically Needy Unit to release the spenddown amount. See 14-I, Changes and Corrections.

WIFS No.	Message Sent To Worker	Definition/Resolution
3059 TXIX	Active aid type and MEPD. MEPD billing stops/possible refund.	An MEPD record and another medical aid type have been received for the same month. The system will stop MEPD billing for that month. Review the case and determine if MEPD should be closed.
3060 TXIX	Med Needy with spenddown and MEPD with unpaid premium – check ABC and SSNI	An MEPD record with a premium and a Medically Needy record with a spenddown have been received for the same month. Review these cases and determine if any should be closed.
3061 TXIX	Active aid type and MEPD – MEPD becomes or remains primary	An MEPD record and a Medically Needy record without a spenddown have been received for the same month. Review the cases to determine if MEPD should be closed or remain open, as it will remain as primary eligibility.
3062 TXIX	Active retro MEPD and other active aid type	The system has received an MEPD record and another active medical record (any kind except a facility/waiver record) for the same month. MEPD billing will be stopped for that month. Determine if one of these cases needs to be closed.
3063 TXIX	Retro MEPD w/prem & other active aid. Determine if MEPD should continue billing	The system has received an active medical aid type and the worker has entered a month of eligibility with a premium on the RETR screen for the same month. Determine if the billing system must keep billing for that month, or if MEPD should be stopped.
3064 TXIX	Active Aid Type and IowaCare—IowaCare billing stops/possible refund	Full Medicaid eligibility has overlaid IowaCare eligibility. MIPS will stop billing. Determine if a refund is appropriate.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

June 27, 2000

GENERAL LETTER NO. 14-C-38

ISSUED BY: Office of Policy Analysis

SUBJECT: Employees' Manual, Title 14, Chapter C, ***MANAGED HEALTH CARE SYSTEMS***, Title page, new; Contents (page 1), new; and pages 1 through 7, new.

Summary

This material on Managed Health Care Systems from Chapter XIV-B(7) is converted to new manual format and renumbered as 14-C to clarify that it is a separate system from the Automated Benefit Calculation System. The chapter includes the following descriptions:

- Health maintenance organizations.
- Iowa Plan for Behavioral Health.
- Patient management (MediPASS).
- The current managed health care status codes, and a Medicaid Eligibility File screen SSNI.
- The managed health care system notices to potential and enrolled recipients.

Effective Date

Upon receipt.

Material Superseded

None (See General Letter XIV-B(7)-10).

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

June 12, 2001

GENERAL LETTER NO. 14-C-39

ISSUED BY: Office of Policy Analysis, Division of Policy and Rule Integration

SUBJECT: Employees' Manual, Title 14, Chapter C, ***MANAGED HEALTH CARE SYSTEMS***, pages 5 and 6, revised.

Summary

Effective July 1, 2001, new managed health care status codes are created to designate children in foster care, PMIC, MHI, and lock-in under the Iowa Plan. Currently, children in foster care, PMIC, and MHI were included as "FMAP, ages 0-17, Iowa Plan" and had managed health care status codes of A or G. The new codes are:

- V Foster care, PMIC, or MHI and lock-in, ages 0-22, Iowa Plan
- W Foster care, PMIC, or MHI, ages 0-9 (inclusive), Iowa Plan
- X Foster care, PMIC, or MHI, ages 10-22 (inclusive), Iowa Plan

Effective Date

July 1, 2001

Material Superseded

Remove the following pages from Employees' Manual, Title 14, Chapter C, and destroy them:

Page	Date
5 and 6	June 27, 2000

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

July 8, 2003

GENERAL LETTER NO. 14-C-40

ISSUED BY: Office of Policy Analysis

SUBJECT: Employees' Manual, Title 14, Chapter C, ***MANAGED HEALTH CARE SYSTEMS***, page 4, revised.

Summary

This chapter is revised to update the "SSNI = Medicaid Eligibility File" screen to match the current system version.

Effective Date

Upon receipt.

Material Superseded

Remove from Employees' Manual, Title 14, Chapter C, page 4, dated June 27, 2000, and destroy it.

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

May 18, 2004

GENERAL LETTER NO. 14-C-41

ISSUED BY: Field Operations Support Unit

SUBJECT: Employees' Manual, Title 14, Chapter C, ***MEDICAL SYSTEMS***, Title page, revised; Contents (page 1), revised, Contents (page 2), new; pages 1 through 7, revised, and pages 8 through 58, new.

Summary

The name of this chapter has been changed from "Managed Health Care Systems" to "Medical Systems." The chapter is revised to:

- Add the following sections currently located in 14-B(4), ***SYSTEM SCREEN INSTRUCTIONS***.
  - Medipass Provider On-Line Display
  - PRSM = Presumptive Medicaid Eligibility
  - SSBI = Buy-in System
  - SSNI = Medicaid Eligibility File
  - SSRD = Recipient File
- Add a new section for WIFS messages.

Effective Date

Upon receipt.

Material Superseded

Remove the entire Chapter C from Employees' Manual, Title 14, and destroy it. This includes the following:

Page	Date
Title page	June 27, 2000
Contents (page 1)	June 27, 2000
1-3	June 27, 2000
4	July 8, 2003
5-6	June 12, 2001
7	June 27, 2000

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

July 13, 2004

GENERAL LETTER NO. 14-C-42

ISSUED BY: Field Operations Support Unit

SUBJECT: Employees' Manual, Title 14, Chapter C, ***MEDICAL SYSTEMS***, Contents (page 2), revised; pages 21, 47, 48, 53, and 54, revised; and pages 54a and 59, new.

Summary

This chapter is revised to:

- Add two new MEPD WIFS messages, numbers 3048 and 3056.
- Add a new section for ***hawk-i*** WIFS messages.
- Add a new HWKI WIFS message, number 4000.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 14, Chapter C, and destroy them:

Page	Date
Contents (page 2)	May 18, 2004
21, 47, 48, 53, 54	May 18, 2004

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

April 29, 2005

GENERAL LETTER NO. 14-C-43

ISSUED BY: Field Operations Support Unit

SUBJECT: Employees' Manual, Title 14, Chapter C, ***MEDICAL SYSTEMS***, Title page, revised; Contents (pages 1 and 2), revised; pages 1 through 59, revised; and pages 60 through 95, new

Summary

This chapter is revised to:

- Add HREF = Referral System information including screens and case actions for referring cases to the HIPP Unit or the ***hawk-i*** program.
- Place the major sections of the chapter in alphabetical order.
- Update the DETL MNTH screen section with current information.
- Update the MEPD screen to reflect added fields.
  - DETL
  - RETR
  - STMT
- Remove the section regarding the obsolete SSRD = Recipient File screen.
- Add new sections for ***hawk-i*** and ISIS WIFS messages.
- Add a new TXIX WIFS message.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 14, Chapter C, and destroy them:

Page	Date
Title page	May 18, 2004
Contents (page 1)	May 18, 2004
Contents (page 2)	July 13, 2004
1-20	May 18, 2004
21	July 13, 2004
22-46	May 18, 2004
47, 48	July 13, 2004
49-52	May 18, 2004
53, 54, 54a	July 13, 2004
55-58	May 18, 2004
59	July 13, 2004

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

March 31, 2006

GENERAL LETTER NO. 14-C-44

ISSUED BY: Field Operations Support Unit

SUBJECT: Employees' Manual, Title 14, Chapter C, ***MEDICAL SYSTEMS***, Contents (page 2), revised; pages 1, 2, 13, 14, 16, 17, 18, 22 through 26, 38, 46, 47, 48, 51, 52, 60, 61, 63, 64, 65, 67, 68, 85, and 90 through 95, revised; and pages 50a through 50m, 64a, and 96 through 99, new.

Summary

This chapter is revised to:

- Add billing screens and WIFS messages for the Medicaid IowaCare Premium System (MIPS).
- Update DHS Intranet link information.
- Update the ***hawk-i*** referral screens and definitions.
- Update the MEPD RETR screen and field descriptions.
- Update information in the SSNI section regarding:
  - Screens
  - PF key functions
  - Fund codes
  - INS field instructions

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 14, Chapter C, and destroy them:

Page	Date
Contents (page 2)	April 29, 2005
1, 2, 13, 14, 16-18, 22-26, 38, 46-48, 51, 52, 60, 61, 63-65, 67, 68, 85, 90-95	April 29, 2005

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

January 19, 2007

GENERAL LETTER NO. 14-C-45

ISSUED BY: Field Operations Support Unit

SUBJECT: Employees' Manual, Title 14, Chapter C, ***MEDICAL SYSTEMS***, Contents (page 2); revised; pages 49, 50, 50a through 50m, 59, 60, 63, 64, 65, 66, 71, 85, and 87 through 99, revised; and pages 48a through 48h and 60a, new.

Summary

This chapter is revised to:

- Update the Medicaid IowaCare Premium System (MIPS) SUMM = Summary screen and field descriptions.
- Add the following screens to the "MIPS BILLING SCREENS" section:
  - MOAK = Monthly Summary counts screen
  - HAPL = MIPS Applied Hardships screen
- Correct coding instructions for MEPD and MIPS statement reprint functions.
- Update language and add and remove WIFS messages.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 14, Chapter C, and destroy them:

Page	Date
Contents (page 2)	March 31, 2006
49, 50	April 29, 2005
50a-50m	March 31, 2006
59	April 29, 2005
60, 63, 64, 65	March 31, 2006
66, 71	April 29, 2005
85	March 31, 2006
87-89	April 29, 2005
90-99	March 31, 2006

Additional Information

Refer questions about this general letter to your area income maintenance administrator.